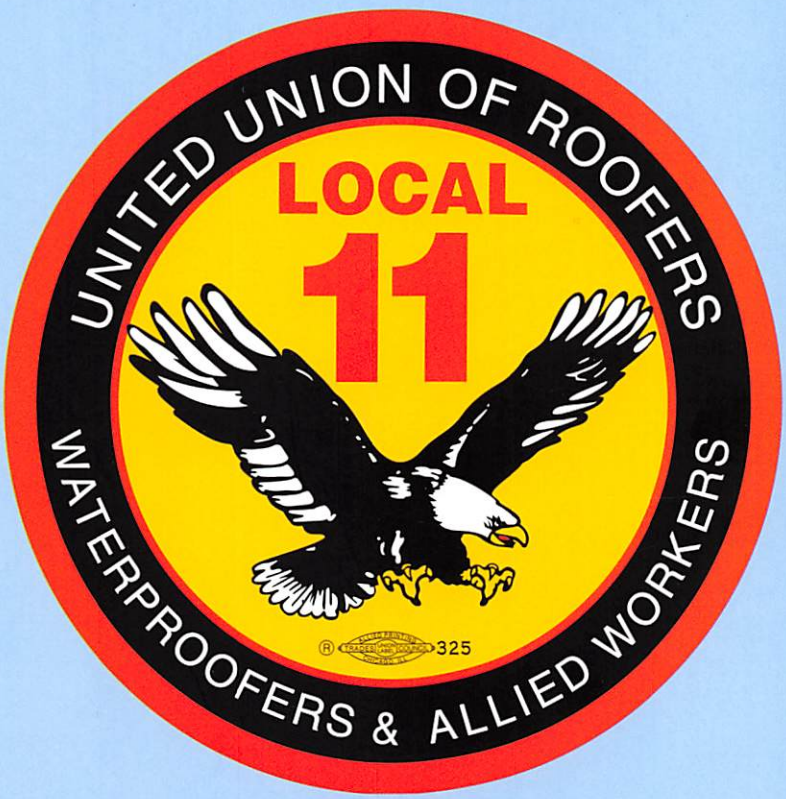
Roofers' Unions Welfare Trust Fund

Summary Plan Description



January 1, 2015 Edition

FUND OFFICE

Roofers' Unions Welfare Trust Fund
2340 S. River Road
Suite 305
Des Plaines, IL 60018-3251

Telephone: (847) 827-1029
Fax: (847) 827-6358

CONTACT INFORMATION

If You Need Information About ...	Contact ...	Contact Information ...
Eligibility, Loss of Life Benefits, Accidental Death and Dismemberment Benefits and Weekly Disability Benefits as well as the status of all claims (except vision claims)	Fund Office Roofers' Unions Welfare Trust Fund 2340 S. River Road, Suite 305 Des Plaines, Illinois 60018-3251 Call 8:00 a.m. to 4:00 p.m. Central Time Monday through Friday	847-827-1029 [phone] 847-827-6358 [fax]
BlueCross BlueShield of Illinois PPO Send Medical PPO and Non-PPO Claims to BCBSIL	BlueCross BlueShield of Illinois P.O. Box 805107 Chicago, Illinois 60680-4112	800-810-2583 [phone]
BCBSIL Participating Doctors and Hospitals	Blue Cross Blue Shield of Illinois (BCBSIL)	800-810-2583 [phone] www.bcbsil.com (select "PPO Plus" option) [web site]
Medical Review Manager Call for precertification of Hospital admissions, non-emergency surgical reviews, occupational therapy, and hospice care	Medical Cost Management (MCM) Call between 7:30 a.m. & 5:30 p.m. Central Time Monday through Friday Live Answering Service Saturday, Sunday & Holidays	800-367-9938 [phone]
Mental Health and Chemical Dependency – Send all claims to ComPsych	ComPsych P.O. Box 8379 Chicago, IL 60680-8379 Call 24-hours a day, 7 days per week	1-877-327-7798 [phone] www.guidance resources.com [web site] Fund ID: MAP_4_RUWTF
Employee Assistance Program (EAP)	ComPsych Call 24-hours a day, 7 days per week	1-877-327-7798 [phone] www.guidance resources.com [web site] Fund ID:MAP_4_RUWTF
Call for precertification of inpatient treatment of mental health and chemical dependency benefits	ComPsych Call 24-hours a day, 7 days per week	1-877-327-7798 [phone] www.guidance resources.com [web site] Fund ID: MAP_4_RUWTF
Diagnostic Imaging Benefits To schedule an MRI, CT scan, or PET scan	Absolute Solutions Call 7:00 a.m. to 7:00 p.m. Central Time Monday through Friday	800-321-5040 [phone] www.absolutedx.com (web site) Email: scheduling@absolutedx.com
Prescription Drug Benefits	Caremark Call Monday through Friday 6:30 a.m. to 9:00 p.m. Central Time and Saturday 8:00 a.m. to 12:00 p.m. Central Time	800-824-6349 [phone] 800-231-4403 (for TDD Assistance) www.caremark.com [web site]
	Specialty Pharmacy Program Available to call 24-hours a day, 7 days per week Specialty Pharmacy Medications must be precertified	800-237-2767 [phone]
Hearing Aid Network To schedule hearing exam	Hear PO Call 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday	888-432-7464 [phone]
Dental Benefits	Dental Network of America Call 8:00 a.m. to 6:00 p.m. Central Time Monday through Friday	866-LABOR-L-U (866-522-6758) [phone] www.dnoa.com [web site]
Vision Benefits	EyeMed Vision Care Call 7:00 a.m. to 10:00 p.m. Monday through Saturday 10:00 a.m. – 7:00 p.m. Sunday	Customer Service 866-723-0513 www.eyemedvisioncare.com To find a network provider: 1-800-988-4221 [phone]

Statement of Grandfathered Status

The Board of Trustees believes that the Plan continues to be a "grandfathered health plan" as that term is defined under the Affordable Care Act, which permits the Plan to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plan is not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plan must comply with certain other provisions of the Affordable Care Act, as described in this Notice.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at (866) 444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

IMPORTANT NOTICE

This SPD is intended to give you an accurate summary of the benefits and provisions of the Plan. The SPD and the Trust Agreement contain a detailed description of the rules, regulations, benefits, and provisions of the Plan. Only the Board of Trustees is authorized to interpret the Plan described in this SPD. The Board of Trustees' interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. Benefits will be paid only when the Board of Trustees, or persons delegated by them to make such decisions, decide, in their sole and unrestricted discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties that such decision will be upheld unless it is determined to be arbitrary or capricious. No agent, representative, officer, or other person from the Union or an employer has the authority to speak for the Trustees or to act contrary to the written terms of the governing Plan documents. If you have questions about your eligibility under the Plan or a claim for benefits, only the Fund Manager or her authorized representatives are authorized to answer your questions for the Trustees.

NOTES ABOUT THIS BOOKLET

PRONOUNS – In this SPD, masculine personal pronouns (he, him, his) include the feminine (she, her, hers) wherever they apply. However, feminine personal pronouns are used when referring to Spouses. If a Spouse is a male, the feminine reference will include the masculine wherever it applies. Also, wherever the term "you" or "your" is used, it refers to an Eligible Employee (or Eligible Retiree, as applicable).

CAPITALIZED TERMS – The capitalized words and terms throughout this SPD are defined terms. The definitions of these words and terms are located in the *Definitions* section.

FAMILY – When this SPD refers to "family," it means an Eligible Employee (or Eligible Retiree), his Spouse and his Children.

BENEFIT AMOUNTS SHOWN IN THIS SPD – Benefits, including the amounts of deductibles and maximum benefits, and the percentages payable by the Plan, are subject to change. To verify the benefits currently available, call the Fund Office.

THE BOARD OF TRUSTEES has full authority to increase, reduce or eliminate benefits and to change any and all provisions of the Plan at any time and from time to time. The Plan is maintained for the exclusive benefit of its participants and beneficiaries.

"Plan," "Plan of Benefits" and "Plans II, II-PA and III" mean the overall benefit program and the scheduled programs of benefits for which an Employee, Retiree or Dependent is or may become eligible for as set forth in the SPD established by, and as it may from time to time be amended by, the Board of Trustees pursuant to the provisions of the Trust Agreement.

WHERE TO GET INFORMATION ABOUT THE PLAN

This SPD contains a summary of your rights and the benefits available under the Roofers' Unions Welfare Trust Fund. To get information about the Plan, write to the Board of Trustees of the Fund at the Fund Office. The address and telephone number of the Fund Office are:

Roofers' Unions Welfare Trust Fund
2340 S. River Road, Suite 305
Des Plaines, Illinois 60018-3251
Telephone: (847) 827-1029
Fax: (847) 827-6358

Fund Office hours are from 8:00 A.M. to 4:00 P.M. (Central Time) Monday through Friday.

DONDE CONSEGUIR INFORMACION SOBRE EL PLAN

Este libro contiene un sumario en Ingles de sus derechos y beneficios disponible segun Roofers' Unions Welfare Trust Fund. Para escribirle a los Directores del Fondo, dirija su carta a la Oficina del Fondo. La direccion y numero de la telefono de la oficina es:

Roofers' Unions Welfare Trust Fund
2340 S. River Road, Suite 305
Des Plaines, Illinois 60018-3251
Telefono: (847) 827-1029
Fax: (847) 827-6358

El horario de la Oficina del Fondo es de Lunes a Viernes 8:00 A.M. a las 4:00 P.M. (Hora Central).

INTRODUCTION

The Board of Trustees of the Roofers' Unions Welfare Trust Fund (Fund) is pleased to provide you with this updated Summary Plan Description (SPD) which also serves as the official Plan Document. This SPD replaces and supersedes prior versions of all previous Plan documents and Summary Plan Descriptions. (The term "Plan" includes the sub-Plans described in this SPD as Plan II, Plan II-PA, Plan III or any future Plans of benefits adopted by the Trustees.) This SPD contains health and welfare benefits information for active and retired participants, effective for claims incurred on and after January 1, 2015.

The Plan offers:

- Medical (including Hospital) benefits;
- Mental Health and Chemical Dependency Benefits;
- Employee Assistance Program (EAP);
- Prescription Drug Benefits;
- Dental Benefits (for eligible Plan II and Plan III participants only);
- Vision Benefits (for eligible Plan II and Plan III participants only);
- Hearing Aid Benefits (for eligible Plan II and Plan III participants only);
- Weekly Disability Benefits (for eligible Plan II, Plan II-PA and Plan III participants only);
- Loss of Life Benefits (for eligible Plan II, Plan II-PA and Plan III participants only); and
- Accidental Death & Dismemberment Benefits (for eligible Plan II, Plan II-PA and Plan III participants only).

This SPD describes all of the benefits that are provided under Plans II,II-PA and III, as described in the different Schedules of Benefits for each separate Plan. Your eligibility for each program is based on whether you meet the eligibility requirements for a particular Plan. ***Although all benefits are described in this SPD, not all benefits are provided under all of the Schedules of Benefits. Therefore, your particular Schedule of Benefits determines which benefits are provided to you. You may not assume you are covered by a benefit because it is described in this SPD. You must consult your Schedule of Benefits for the specific benefits and amount of benefits provided to you. You may also call the Fund Office if you have questions about your benefits. However, the written provisions set forth in this SPD will control all benefit claim determinations.***

It is the Trustees' goal to maintain a financially sound Fund while providing adequate health care coverage to you and your family. The Fund has implemented cost-control methods such as medical deductibles and out-of-pocket payments to ensure that the Fund can meet your current and future health care needs. You can help manage health care costs for you and the Fund by:

- **Using network providers** – Network providers, which include Hospitals, Physicians, and other health care providers, charge negotiated, reduced rates. In addition, the Plan generally pays a higher percentage when you use a network provider.
- **Examining emergency treatment alternatives** – In the event of a Medical Emergency, the most important consideration is to seek immediate medical care, especially in a life-threatening situation. However, in some cases, you can obtain the same level of care at a Doctor's office or an

urgent care facility as in a Hospital emergency room. Keep your Doctor's telephone number accessible and locate the nearest facility so you will be prepared in case of a Medical Emergency.

- **Precertifying services** – Certain services under the Plan, including Hospital admission, non-emergency surgery over $5,000 and treatment for inpatient mental health conditions and chemical dependency require precertification. If these services are not precertified, you will be subject to a non-compliance deductible. or you may not receive coverage.

- **Requesting generic medications** – Often medications come in two forms: generic and brand name. By law, generic medications have to meet the same quality standards for pureness and effectiveness, but can cost much less than brand name equivalents. Ask your Doctor if a generic medication is available and medically appropriate.

- **Using the Maintenance Choice prescription medication program** – The Maintenance Choice prescription medication program is a convenient way to receive maintenance medications delivered to your home or picked up at your local CVS Pharmacy. When you use the Maintenance Choice prescription medication program, you generally pay less for a larger supply of medication.

Neither you nor your eligible Dependents acquire any vested right to Plan benefits either before or after your retirement. The Trustees may, and they reserve the right at any time and from time to time, to:

- amend or terminate the Plan; and/or

- expand, reduce, or cancel coverage for active participants, Dependents, and/or Eligible Retirees.

Benefits under the Plan will be paid only when the Board of Trustees, or persons delegated by them to make such decisions, decides, in their sole and unrestricted discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan.

We urge you to read this information and, if you are married, share it with your Spouse. Also, please keep this SPD with your important papers so you can refer to it when needed.

Sincerely,

Board of Trustees
Roofers' Unions Welfare Trust Fund

Table of Contents

SCHEDULE OF BENEFITS – PLAN II 1

SCHEDULE OF BENEFITS – PLAN II-PA 5

SCHEDULE OF BENEFITS – PLAN III 8

ELIGIBILITY FOR PLAN II AND III ACTIVE EMPLOYEES AND THEIR DEPENDENTS 12

- INITIAL ELIGIBILITY REQUIREMENTS 12
- INITIAL ELIGIBILITY - WHEN BENEFITS START (ALL PLAN II AND III EMPLOYEES) 14
- CONTINUING ELIGIBILITY (ALL PLAN II AND III EMPLOYEES) 15

ELIGIBILITY FOR PLAN II-PA ACTIVE EMPLOYEES 17

- INITIAL ELIGIBILITY REQUIREMENTS 17
- INITIAL ELIGIBILITY - WHEN BENEFITS START (ALL PLAN II-PA EMPLOYEES) 17
- CONTINUING ELIGIBILITY (ALL PLAN II-PA EMPLOYEES) 18

ELIGIBILITY FOR OWNERS AND SPOUSES OF OWNERS OF ROOFING CONRACTORS 19

- INITIAL AND CONTINUING ELIGIBILITY FOR OWNERS AND SPOUSES OF OWNERS OF ROOFING CONTRACTORS 19

ELIGIBILITY FOR ACTIVE EMPLOYEES - OTHER PROVISIONS 20

- ELIGIBILITY DURING DISABILITY 20
- WORKING AT THE CRAFT OUTSIDE LOCAL 11 JURISDICTION 20
- SPECIAL ENROLLMENT FOR PLANS II AND III 21
- TERMINATION OF EMPLOYEE ELIGIBILITY 21
- REGULAR SELF-PAYMENTS FOR PLAN II AND PLAN III 22
- RETURN TO COVERED EMPLOYMENT 25
- TERMINATION OF DEPENDENT ELIGIBILITY (PLAN II AND III ONLY) 25
- BENEFITS FOR DEPENDENTS OF DECEASED ELIGIBLE EMPLOYEES 26

ELIGIBILITY AND BENEFITS FOR RETIREES AND THEIR DEPENDENTS 29

- ELIGIBILITY FOR RETIREE BENEFITS 29
- EARLY RETIREMENT (RETIREMENT AT AGES 55 THROUGH 59) 29
- NORMAL RETIREMENT (RETIREMENT AT AGES 60 THROUGH 64) 30
- SPECIAL EARLY RETIREMENT (RETIREMENT AT AGES 58 THROUGH 59) 30
- DISABILITY RETIREMENT 32
- BENEFITS FOR SURVIVING DEPENDENTS OF ELIGIBLE RETIREES 33
- COBRA CONTINUATION COVERAGE FOR DEPENDENTS OF ELIGIBLE RETIREES 33
- TERMINATION OF ELIGIBILITY FOR RETIREE BENEFITS 34
- WHEN YOU ARE AGE 65 36

LIFE EVENTS 37
NOTIFY THE FUND OFFICE 37
ADDING A DEPENDENT 37
IF YOUR DEPENDENT LOSES ELIGIBILITY FOR COVERAGE 37
IN THE EVENT OF DIVORCE 37
QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) 38
IF YOU TAKE LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA) 38
IF YOU ENTER ACTIVE MILITARY SERVICE 39
IN THE EVENT YOU BECOME DISABLED 40
IN THE EVENT OF YOUR DEATH 40

COBRA CONTINUATION COVERAGE 41
QUALIFYING EVENTS/MAXIMUM COVERAGE PERIODS 41
NOTIFICATION RESPONSIBILITIES 42
BENEFITS UNDER COBRA COVERAGE 42
ELECTION NOTICES AND FORMS 42
ELECTING COBRA COVERAGE 43
COBRA PAYMENT RULES 43
TERMINATION OF COBRA COVERAGE 43
CERTIFICATION OF CREDITABLE COVERAGE 44

LOSS OF LIFE BENEFIT 45
LOSS OF LIFE BENEFITS 45

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT 47
PAYMENT OF BENEFITS 47
EXCLUSIONS AND LIMITATIONS 47

WEEKLY DISABILITY BENEFIT 49
WEEKLY DISABILITY BENEFITS 49
PAYMENT OF BENEFITS/WHEN BENEFITS START 49
PERIODS OF DISABILITY 49
EXCLUSIONS AND LIMITATIONS 50

COMPREHENSIVE MEDICAL EXPENSE BENEFIT (COMPREHENSIVE BENEFIT) 51
HOW THE COMPREHENSIVE BENEFIT WORKS 51
COVERED MEDICAL EXPENSES 54
EMPLOYEE ASSISTANCE PROGRAM 65
BENEFITS FOR TREATMENT OF CHEMICAL DEPENDENCY 65
BENEFITS FOR TREATMENT OF MENTAL OR NERVOUS DISORDERS 67
BENEFITS FOR HOSPICE CARE 68

PRESCRIPTION DRUG PROGRAM 71

RETAIL PHARMACY CARD PROGRAM 71
MAINTENANCE CHOICE PROGRAM 71
SPECIALTY PHARMACY PROGRAM 72
EXCLUSIONS AND LIMITATIONS 73

DENTAL EXPENSE BENEFITS - PLANS II AND III 75
DENTAL PREFERRED PROVIDER ORGANIZATION (DENTAL PPO) 75
DENTAL EXPENSE BENEFIT – HOW IT WORKS 75
ORTHODONTIA EXPENSE BENEFITS - PLANS II AND III 78
PERIODONTAL EXPENSE BENEFITS - PLANS II AND III 80

VISION CARE EXPENSE BENEFIT – PLANS II AND III 81
NETWORK BENEFITS 81
NON-NETWORK BENEFITS 81
VISION CARE BENEFIT EXCLUSIONS AND LIMITATIONS 81
EXTENSION OF VISION BENEFITS 82

PLAN CONDITIONS, LIMITATIONS AND EXCLUSIONS 83
NO PLAN PAYMENT WILL BE MADE FOR ANY LOSS SUSTAINED AS A RESULT OF OR FOR CHARGES INCURRED FOR OR AS A RESULT OF: 83

WHERE TO FILE CLAIMS AND HOW TO COLLECT BENEFITS 86
ALL MEDICAL CLAIMS OTHER THAN MENTAL HEALTH, CHEMICAL DEPENDENCY AND DIAGNOSTIC IMAGING CLAIMS 86
MENTAL HEALTH AND CHEMICAL DEPENDENCY CLAIMS 86
DIAGNOSTIC IMAGING NETWORK CLAIMS 86
DENTAL CLAIMS 86
VISION CLAIMS 87
HEARING AID CLAIMS 87
WEEKLY DISABILITY CLAIMS 87
LOSS OF LIFE CLAIMS 87
ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) CLAIMS 88

CLAIM AND APPEAL PROCEDURES 89
FILING A CLAIM 89
TIME PERIODS FOR PROCESSING CLAIMS 89
DENIAL OF CLAIMS 92
LEGAL PROCEEDINGS 95
ASSIGNMENT OF BENEFITS 95
BENEFIT PAYMENT TO AN INCOMPETENT PERSON 95

DEFINITIONS 97

GENERAL PLAN PROVISIONS 106

ENROLLMENT IN MEDICARE 109
FUND RIGHT OF SUBROGATION (REIMBURSEMENT) 109
PAYMENT OF BENEFITS 110
DISCOUNTS, SETTLEMENTS AND REBATES 111
EXAMINATIONS 111
TRUSTEE AUTHORITY AND INTERPRETATION 111
CIRCUMSTANCES THAT MAY RESULT IN CLAIM DENIALS OR LOSS OF BENEFITS 112
HIPAA CERTIFICATES OF COVERAGE 113
MISREPRESENTATION OR FALSIFICATION OF A CLAIM 113
GOVERNING LAW 113
SEVERABILITY CLAUSE 114
WORKERS' COMPENSATION 114
RIGHT OF RECOVERY 114
RELEASE OF INFORMATION 114
QUALIFIED MEDICAL CHILD SUPPORT ORDERS 115
TERMINATION OF PLAN 115

ERISA RIGHTS 116
RECEIVE INFORMATION ABOUT THE PLAN AND YOUR BENEFITS 116
CONTINUE GROUP HEALTH PLAN COVERAGE 116
PRUDENT ACTIONS BY PLAN FIDUCIARIES 117
ENFORCE YOUR RIGHTS 117
ASSISTANCE WITH YOUR QUESTIONS 117

INFORMATION ABOUT THE PLAN OF BENEFITS 119
NAME OF PLAN 119
PLAN SPONSORSHIP AND ADMINISTRATION 119
SERVICE OF LEGAL PROCESS 119
SOURCE OF FINANCING; PLAN PARTICIPATION 119
ACCUMULATION OF ASSETS; PAYMENT OF BENEFITS 119
PLAN YEAR 119
FUND/PLAN IDENTIFICATION NUMBERS 120
COLLECTIVE BARGAINING AGREEMENT 120

Preferred Provider Organization (PPO)

The name and contact information of the Plan's Preferred Provider Organization (PPO) network can be found on the inside front cover. The providers participating in the PPO network will provide inpatient and outpatient care to you and your family at discounted charges to the Plan.

You and your family are not required to use PPO providers. You do not have to sign up to use them. You can use a PPO provider one time and a non-PPO provider the next time. Some members of your family can use PPO providers while others use non-PPO providers. However, if you use non-PPO providers:

- The Plan pays a lower copay percentage of the Covered Medical Expenses you incur at non-PPO providers.
- You must pay an additional non-PPO Hospital deductible each time you or any of your Dependents is admitted as an inpatient to a non-PPO Hospital.
- You must pay an additional deductible for each office visit with a non-PPO Doctor. This deductible applies each time you or any of your Dependents receive office services provided by a non-PPO Doctor.
- The Plan does not cover surgical procedures performed at non-PPO network Outpatient Surgical Facilities (including surgeon's services, anesthesia, radiology, pathology, drugs, and any other miscellaneous charges).

Participants in the Plan receive an I.D. card. Call the Fund Office if you did not receive one. If your current Doctor is not in the PPO network and you would like to find a PPO Doctor, use the telephone number or website for the PPO or just call the Doctor's office and ask if the Doctor is in the Plan's PPO network.

Be sure to show your I.D. card whenever any medical services are received. Your I.D. card alerts the provider that the claim should be filed directly with the PPO. However, if special circumstances require you to file a claim incurred within the State of Illinois yourself, be sure to send all medical bills (PPO and non-PPO) directly to the PPO. (The address of the Illinois PPO office is on the inside front cover.) To locate a participating PPO provider when traveling, please call the telephone number shown on the inside front cover.

Emergency Care In Non-PPO Hospitals

If a non-PPO Hospital is used for an Emergency Admission or for treatment of a Medical Emergency, the Plan will pay the Covered Medical Expenses incurred for that treatment at the PPO copay percentage. The PPO copay percentage will be applied to Covered Medical Expenses regardless of whether services are rendered by PPO or non-PPO providers or if a Hospital admission is ordered by a PPO or non-PPO Doctor. (The terms Emergency Admission and Medical Emergency have specific meanings and are defined in the *Definitions* section of this booklet.)

Review Programs

Precertification for Hospital Admission (other than for Mental Health /Chemical Dependency)

The contact information for the Medical Review Manager is shown on the inside front cover.

If you or a Dependent are scheduled to be hospitalized, you must notify the Medical Review Manager to obtain precertification **before the Hospital admission.** This notification must be made whether a PPO or non-PPO Hospital will be used. You will be asked for some basic information about the patient and the admission. For an **Emergency Admission**, you must notify the Medical Review Manager **within 24 hours** after the admission occurs. Either you, your Dependent, a family member, the attending Doctor, or a Hospital can notify the Medical Review Manager, **but it is your responsibility to ensure that the notification is made.** After each admission, whether scheduled or emergency, the Medical Review Manager will stay in contact with your Doctor and follow up throughout the length of the Hospital stay.

You and your Doctor will always make the final decisions on medical and mental health and chemical dependency treatment for you and your family. However, the Plan will pay benefits only for treatment that is precertified as having been determined by the appropriate Review Manager to be Medically Necessary. In addition, no benefits are payable after an applicable maximum benefit has been reached, even if the treatment was Medically Necessary.

If you or a Dependent are admitted to a Hospital for the treatment of a mental health and/or chemical dependency condition, you must notify the Mental Health and Chemical Dependency Review Manager, rather than the Medical Review Manager. The contact information for the Mental Health and Chemical Dependency Review Manager is on the inside front cover.

Hospital Review Noncompliance Deductible

If you do not precertify a hospital admission or if you do not notify the Medical Review Manager about a Hospital admission or an emergency admission within 24 hours after the admission occurs, (whether it's for a medical purpose or for a mental health and/or chemical dependency purpose) as required above, an additional **Hospital Review Noncompliance Deductible** will be applied to the Covered Medical Expenses incurred for that Hospital stay, in addition to any other deductibles that may apply. See the Schedule of Benefits applicable to you for the amount of the Hospital Review Noncompliance Deductible.

Surgery Review Program

The following rules apply to all inpatient and outpatient surgery that costs $5,000 or more, whether the surgery is performed in a PPO or non-PPO Hospital, in a Doctor's office, or in another facility. However, the Plan does not cover surgical procedures (including surgeon's services, anesthesia, radiology, pathology, drugs and other miscellaneous charges) performed at non-PPO network Outpatient Surgical Facilities.

The Plan's Medical Review Manager will review proposed non-emergency surgery to determine if it meets the Plan's definition of Medically Necessary and may require you to obtain a second surgical opinion if it deems it appropriate. The Surgery Review Program is not intended to restrict the care you and your family may receive, but only to determine if such care is covered under the Plan.

What You Have to Do

If any non-emergency surgery that costs $5,000 or more (surgery performed on a basis other than due to a Medical Emergency) is proposed for you or a Dependent, you must notify the Medical Review Manager before the surgery to find out if the facts and circumstances of your condition warrant a second surgical

opinion. If a second opinion is required, the Medical Review Manager will provide a choice of Doctors to provide the second opinion. If the second opinion does not determine that the proposed surgery is Medically Necessary, you can obtain a third opinion from one of the Doctors specified by the Medical Review Manager. The Plan will not cover the proposed surgery unless the second (or third) opinion determines that the proposed surgery is Medically Necessary. The Plan will pay 100% of the Covered Medical Expenses you incur for a second (and third) opinion recommended by the Medical Review Manager.

Surgery Review Noncompliance Deductible

If you do not notify the Medical Review Manager about surgery as explained above, an additional Surgery Review Noncompliance Deductible will be applied to the Covered Medical Expenses incurred for and in connection with each surgery, in addition to any other deductibles and Plan provisions that may apply.

If a required second surgical opinion is not obtained, an additional Surgery Review Noncompliance Deductible will be applied to the Covered Medical Expenses incurred for and in connection with each surgery, subject to a determination that the surgery was Medically Necessary, in addition to any other deductibles and Plan provisions that may apply.

You, your Dependent, a family member, the attending Doctor, or a Hospital can notify the Medical Review Manager, **but it is your responsibility to ensure that the notification is made.**

REVIEW MANAGER'S CERTIFICATION LETTERS

After notification has been made to the appropriate Review Manager about a proposed Hospital admission, or to the Medical Review Manager about a proposed surgery, you will be advised that the review procedure was followed and whether the proposed services are considered Medically Necessary.

The Review Manager will issue either a precertification letter or a denial letter. A precertification letter does not guarantee payment of benefits, only that the proposed services are considered Medically Necessary. All benefit payments are subject to the Plan's eligibility and coverage limitations.

Mental Health and Chemical Dependency Review and Precertification Program

The Plan's precertification program applies to inpatient treatment of Chemical Dependency and Mental or Nervous Disorders. The Mental Health and Chemical Dependency Review Manager provides review and precertification for inpatient treatment, continuing stay authorization, discharge planning, and aftercare monitoring for all treatment of these conditions. The Mental Health and Chemical Dependency Review Manager can also help with problems and assist you in finding an appropriate Doctor, therapist, facility, etc.

You must notify the Mental Health and Chemical Dependency Review Manager to precertify treatment as being Medically Necessary prior to any Mental Health or Chemical Dependency inpatient treatment.

If you or your Dependents need inpatient Hospitalization (including partial Hospitalization), you must notify the Mental Health and Chemical Dependency Review Manager before the admission or treatment begins. For emergency admissions, you must notify the Mental Health and Chemical Dependency Review Manager within 24 hours of an Emergency Admission.

While it is ultimately your responsibility to ensure the Mental Health and Chemical Dependency Review Manager is notified, you, your Dependents, a family member, the attending Doctor or the Hospital can also notify the Mental Health and Chemical Dependency Review Manager for precertification.

How Benefits are Paid When Mental Health Treatment is Not Precertified

If you do not certify an inpatient confinement or partial confinement *before the commencement of that confinement (or within 24 hours of an Emergency Admission)* and it is later determined that the admission was Medically Necessary, your benefits will be reduced by the Covered Medical Expenses incurred for the days of confinement before the notification was made or **the Mental Health and Chemical Dependency Noncompliance Deductible,** whichever is less.

Mental Health and Chemical Dependency Provider Network

The Mental Health and Chemical Dependency Provider Network has a nationwide network of counselors, social workers, psychologists, psychiatrists and facilities. If you use a Mental Health and Chemical Dependency Network Provider, the Fund will pay a higher percentage of the claim than if you use a non-network provider.

Employee Assistance Program

The Plan provides an Employee Assistance Program (EAP) through the Mental Health and Chemical Dependency Review Manager. The EAP also provides a network of Mental Health and Chemical Dependency Providers and handles all claims for these types of treatment. The EAP's toll-free telephone number and website are listed on the inside front cover. The telephone number is also on your I.D. card.

The EAP's website can provide you and your family with valuable information about wellness, along with resources to assist in the daily demands of work and home. The website has information on how to access the EAP program and an outline of the Plan's benefits for Mental Health and Chemical Dependency treatment.

You and your Dependents may also call the EAP to obtain help coping with the daily demands of work and home.

- **The EAP is available by telephone 24 hours a day, 7 days a week.**

- **The EAP will provide confidential assistance with a variety of personal or workplace problems at no additional cost to you.** The problems for which help is provided include stress, depression, grief and marital difficulties. Resources and services that are available through the EAP include counselors in your area who have experience working with your issue or problem; legal and financial resources; family mediation referrals; child and elder care information; and general community-based resources, family service agencies, battered women shelters, drug and alcoholism support groups, and parenting groups.

- **The Plan provides up to six (6) EAP sessions per problem per Calendar Year at no additional cost to you.** The number of EAP sessions that you use will depend on the EAP Specialist's assessment of your needs. Although these EAP sessions are provided to you and your Dependents at no cost to you, your sessions must be preauthorized by calling the EAP's toll-free telephone number. When you call, the EAP Specialist will initially authorize some assessment sessions and will give you a "certification number" that authorizes you to see an EAP Network Provider for face-to-face appointments. Once your EAP Network Provider has made an assessment and determined your needs, he or she will contact the EAP to make treatment recommendations, if necessary.

- **If you need Mental Health or Chemical Dependency treatment,** your EAP Network Provider may recommend and authorize the necessary treatment. Coverage for Medically Necessary treatment beyond the EAP sessions will be determined under the Plan's benefit provisions for these conditions.

SCHEDULE OF BENEFITS

SCHEDULE OF BENEFITS – PLAN II

Loss of Life Benefit		
Loss of Life – Employee Only	$4,000	
Accidental Death & Dismemberment Benefit		
(Non-occupational or non-work connected accidental death or dismemberment – Employee Only)		
Loss of Life	$4,000	
Loss of two hands, two feet, or sight of two eyes	$4,000	
Loss of one foot & sight in one eye, or one hand & sight in one eye, or one hand & one foot	$4,000	
Loss of one hand, one foot, or sight in one eye	$2,000	
Weekly Disability Benefit		
(Applies to non-occupational or non-work connected sickness or injury – Employee Only)		
Weekly Benefit	$210	
Maximum Period	22 weeks	
Day of disability benefits begin:		
Disability due to accidental injury	1st day	
Disability due to sickness	8th day	
Comprehensive Medical Expense Benefits		
	PPO Provider	**Non-PPO Provider**
Calendar Year Maximum	Unlimited	
Calendar Year Deductibles		
Individual	$250	
Family (3 Individual Deductibles)	$750	
Calendar Year Out-of-Pocket Maximums		
Individual	$1,800	
Family	$3,000	
Non-PPO Hospital Deductible	$250 per Covered Person for each confinement	
Non-PPO Doctor Deductible	$5 per Covered Person for each office visit with a Non-PPO Doctor	
Hospital – Inpatient and outpatient services & supplies (other than outpatient surgery)	Plan pays 80%	Plan pays 70%
Hospital Review Noncompliance Deductible (includes admissions for mental health & chemical dependency)	$200	
Second and Third Surgical Opinions (applies to non-emergency inpatient and outpatient surgeries which cost $5,000 or more when required by the Review Organization)	Plan pays 100%; Not subject to Calendar Year Deductible	
Surgery Review Program Non-Compliance Deductible	$200	
Non-emergency Outpatient Surgery (When performed in a Hospital outpatient department or in an outpatient surgical facility)		
Covered Medical Expenses incurred for facility services incurred on the date of surgery	Plan pays 80% (in a PPO Hospital and PPO Outpatient Surgical Facility)	Plan pays 70% (in a Non-PPO Hospital) No Coverage for a Non-PPO Outpatient Surgical Facility
Covered Medical Expenses incurred for surgeons' services, anesthesia, radiology, pathology, drugs, and other miscellaneous services and supplies provided on the date of surgery	Plan pays 80% (in a PPO Hospital or PPO Outpatient Surgical Facility)	Plan pays 80% (in a Non-PPO Hospital) No coverage when performed in a Non-PPO Outpatient Surgical Facility
Skilled Nursing Facility Care	Plan pays 80%	Plan pays 70%
Maximum days of confinement	90 days per Calendar Year	
Private Duty Nursing	Plan pays 80%; Not subject to Calendar Year Deductible	
Maximum Nursing Shifts	90 Shifts per Calendar Year	

Comprehensive Medical Expense Benefits	PPO Provider	Non-PPO Provider
Hospice Care	Plan pays 80%	Plan pays 70%
Lifetime Maximum per Covered Person	$10,000	
Home Care Allowance	6 hours per day (up to 24 hours per day during a period of crisis)	
Emergency Room (applies to Medical Emergency treatment)	Plan pays 80% of Covered Medical Expenses at PPO level when either a PPO or Non-PPO Hospital is used	
Emergency Room Deductible	$50 per visit	
Deductible for failure to precertify within 24 hours after Emergency Admission	$200	
First Aid Treatment		
Covered Medical Expenses incurred within first 72 hours after an injury	Plan pays 100% up to $200 Subject to the Emergency Room Deductible	
Covered Medical Expenses in excess of $200 and/or which are incurred more than 72 hours after an injury	Plan pays 80% Subject to the Calendar Year Deductible	
Routine Physical Examinations – From birth to below age 19	Plan pays 100% Not subject to Calendar Year Deductible	
Routine Physical Examinations – Covered Persons over age 18	Plan pays 100% every 36 months; Not subject to Calendar Year Deductible	
Prostate Specific Antigen (PSA) Test and Prostate Examination (For Covered Persons age 40 or older and under age 65)	Plan pays 100% up to $150; Not subject to Calendar Year Deductible	
Gynecological Examinations (Includes up to two gynecological exams per Calendar Year, including pap smears and bilateral mammograms as well as HPV screening every 3 years for Covered Persons who are female over age 30)	Plan pays 100%; Not subject to Calendar Year Deductible	
Colorectal Cancer Screenings (Includes Covered Medical Expenses incurred for fecal occult blood tests (FOBT), sigmoidoscopies, and double contrast barium enema (DCBE) tests performed in accordance with the criteria and frequency described in the Covered Medical Expense Benefit Section)	Plan pays 80%	
Physical Therapy	Plan pays 80%	
Maximum Number of Treatments Per Calendar Year	26 per Covered Person	
Occupational Therapy Maximum benefit per Calendar Year	Plan pays 80% $5,000 per Covered Person	
Hearing Aids	Plan pays 100% of first $500 per Covered Person	
Every 3 calendar years	Plan pays 80% of balance if PPO used	Plan pays 70% of balance if non-PPO used
Diagnostic Imaging	Plan pays 100%	Plan pays 80%
Chiropractic Treatment Maximum Calendar Year Benefit	Plan pays 80% $2,000 per Covered Person	

Comprehensive Medical Expense Benefits	PPO Provider	Non-PPO Provider
Infertility Treatment	Plan pays 80%	Plan pays 70%
Maximum Calendar Year Benefit		
Testing & Medical/Surgical	$5,000	
Prescription Drugs	$5,000	
Maximum Lifetime Benefits		
Testing & Medical/Surgical	$25,000	
Prescription Drugs	$25,000	
Mental and Nervous Disorders		
Precertification Non-Compliance Deductible (applies to inpatient treatment only)	$200	
Inpatient Treatment	Plan pays 80%	Plan pays 70%
Outpatient Treatment	Plan pays 80%	Plan pays 70%
Copayment	None	Covered Person pays $5 per visit
Chemical Dependency		
Precertification Non-Compliance Deductible (applies to inpatient treatment only)	$200	
Inpatient Treatment	Plan pays 80%	Plan pays 70%
Outpatient Treatment	Plan pays 80%	Plan pays 70%
All Other Covered Medical Expenses	Plan pays 80%	
Prescription Drug Benefit		
Retail Pharmacy Card (30-day supply) (Applies to short-term and acute medications)		
Brand Name and Generic	Plan pays 80% and Covered Person pays 20%	
Maintenance Choice Program (up to 90-day supply) (Applies to long-term and maintenance medications as determined by PBM)		
Copays		
Brand Name (when no generic available)	$40	
Brand Name (when generic available)	$60	
Generic	$15	
Note 1: Maintenance drugs can only be filled at the time of the initial prescription plus one refill at the retail level. After that, a Covered Person must use the Maintenance Choice Program or prescription drugs will not be covered.		
Note 2: Medications filled through the Specialty Pharmacy Program must be precertified by the PBM, otherwise the medications are not covered.		
Dental Benefits		
Calendar Year Maximum		
Individual	$1,500	
Family	$3,750	
Calendar Year Deductible		
Individual	$10	
Family (3 Individual Deductibles)	$30	
Routine Services	Plan pays 100% every 6 months; Deductible does not apply	
Basic Services	Plan pays 80%	
Complete Denture Replacement	Plan pays 50% once every 60 consecutive months, after 12 months of eligibility	

Orthodontia Benefit	Plan pays 50%	
Lifetime Maximum	$1,500 per Covered Person	
Periodontal Benefit	Plan pays 80%	
Lifetime Maximum	$2,000 per Covered Person	
Vision Benefit	**PPO Provider**	**Non-PPO Provider**
Standard Exam – Once every Calendar Year	Plan pays 100%	Plan pays 100% up to $30
Exam Options		
Standard Contact Lens Fit & Follow-Up	Plan pays 100% up to $40	No coverage
Premium Contact Lens Fit & Follow-Up	Covered Person pays 100% at a 10% discount off of retail price	No coverage
Frames – Once every Calendar Year	Plan pays 100% up to $100; Covered Person pays remaining amount at a 20% discount off of retail price	Plan pays 100% up to $30
Standard Plastic Lenses – Once every Calendar Year	Plan pays 100% after $5 copay for single vision lenses, $12.50 for bifocals, and $32.50 for trifocals	Plan pays 100% up to $50
Lens Options • UV Coating • Tint (solid & gradient) • Standard Scratch Resistance • Standard Polycarbonate • Standard Anti-Reflective Coating • Standard Progressive (add-on) • Other Add-ons and Services	Covered Person pays: $15 $15 $15 $40 $45 $65 Entire amount at 20% discount off of retail price	Not covered
Contact Lenses – Once every Calendar Year		
Conventional Lenses	Plan pays 100% up to $100; Covered Person pays remaining amount at a 20% discount off of retail price	Plan pays 100% up to $50
Disposable Lenses	Plan pays 100% up to $100	Plan pays 100% up to $50
Medically Necessary Lenses	Plan pays 100%	Plan pays 100% up to $200

SCHEDULE OF BENEFITS – PLAN II-PA

Loss of Life Benefit		
Loss of Life – Employee Only	$4,000	
Accidental Death & Dismemberment Benefit		
(Non-occupational or non-work connected accidental death or dismemberment – Employee Only)		
Loss of Life	$4,000	
Loss of two hands, two feet, or sight of two eyes	$4,000	
Loss of one foot & sight in one eye, or one hand & sight in one eye, or one hand & one foot	$4,000	
Loss of one hand, one foot, or sight in one eye	$2,000	
Weekly Disability Benefit		
(Applies to non-occupational or non-work connected sickness or injury – Employee Only)		
Weekly Benefit	$210	
Maximum Period	22 weeks	
Day of disability benefits begin:		
Disability due to accidental injury	1st day	
Disability due to sickness	8th day	
Comprehensive Medical Expense Benefits		
	PPO Provider	**Non-PPO Provider**
Calendar Year Maximum	Unlimited	
Calendar Year Deductibles		
Individual	$250	
Family (3 Individual Deductibles)	$750	
Calendar Year Out-of-Pocket Maximums		
Individual	$1,800	
Family	$3,000	
Non-PPO Hospital Deductible	$250 per Covered Person for each confinement	
Non-PPO Doctor Deductible	$5 per Covered Person for each office visit with a Non-PPO Doctor	
Hospital – Inpatient and outpatient services & supplies (other than outpatient surgery)	Plan pays 80%	Plan pays 70%
Hospital Review Noncompliance Deductible (includes admissions for mental health & chemical dependency)	$200	
Second and Third Surgical Opinions (applies to non-emergency inpatient and outpatient surgeries which cost $5,000 or more when required by the Review Organization)	Plan pays 100%; Not subject to Calendar Year Deductible	
Surgery Review Program Non-Compliance Deductible	$200	
Non-emergency Outpatient Surgery (When performed in a Hospital outpatient department or in an outpatient surgical facility)		
Covered Medical Expenses incurred for facility services incurred on the date of surgery	Plan pays 80% (in a PPO Hospital and PPO Outpatient Surgical Facility)	Plan pays 70% (in a Non-PPO Hospital) No Coverage for a Non-PPO Outpatient Surgical Facility
Covered Medical Expenses incurred for surgeons' services, anesthesia, radiology, pathology, drugs, and other miscellaneous services and supplies provided on the date of surgery	Plan pays 80% (in a PPO Hospital or PPO Outpatient Surgical Facility)	Plan pays 80% (in a Non-PPO Hospital) No coverage when performed in a Non-PPO Outpatient Surgical Facility
Skilled Nursing Facility Care	Plan pays 80%	Plan pays 70%
Maximum days of confinement	90 days per Calendar Year	
Private Duty Nursing	Plan pays 80%; Not subject to Calendar Year Deductible	
Maximum Nursing Shifts	90 Shifts per Calendar Year	

Comprehensive Medical Expense Benefits	PPO Provider	Non-PPO Provider
Hospice Care	Plan pays 80%	Plan pays 70%
Lifetime Maximum per Covered Person	$10,000	
Home Care Allowance	6 hours per day (up to 24 hours per day during a period of crisis)	
Emergency Room (applies to Medical Emergency treatment)	Plan pays 80% of Covered Medical Expenses at PPO level when either a PPO or Non-PPO Hospital is used	
Emergency Room Deductible	$50 per visit	
Deductible for failure to precertify within 24 hours after Emergency Admission	$200	
First Aid Treatment		
Covered Medical Expenses incurred within first 72 hours after an injury	Plan pays 100% up to $200 Subject to the Emergency Room Deductible	
Covered Medical Expenses in excess of $200 and/or which are incurred more than 72 hours after an injury	Plan pays 80% Subject to the Calendar Year Deductible	
Routine Physical Examinations – From birth to below age 19)	Plan pays 100% Not subject to Calendar Year Deductible	
Routine Physical Examinations – Covered Persons over age 18	Plan pays 100% every 36 months; Not subject to Calendar Year Deductible	
Prostate Specific Antigen (PSA) Test and Prostate Examination (For Covered Persons age 40 or older and under age 65)	Plan pays 100% up to $150; Not subject to Calendar Year Deductible	
Gynecological Examinations (Includes up to two gynecological exams per Calendar Year, including pap smears and bilateral mammograms as well as HPV screening every 3 years for Covered Persons who are female over age 30)	Plan pays 100%; Not subject to Calendar Year Deductible	
Colorectal Cancer Screenings (Includes Covered Medical Expenses incurred for fecal occult blood tests (FOBT), sigmoidoscopies, and double contrast barium enema (DCBE) tests performed in accordance with the criteria and frequency described in the Covered Medical Expense Benefit Section)	Plan pays 80%	
Physical Therapy	Plan pays 80%	
Maximum Number of Treatments Per Calendar Year	26 per Covered Person	
Occupational Therapy Maximum benefit per Calendar Year	Plan pays 80% $5,000 per Covered Person	
Hearing Aids	Plan pays 100% of first $500 per Covered Person	
Every 3 calendar years	Then 80% of balance if PPO used	Then 70% of balance if non-PPO used
Diagnostic Imaging	Plan pays 100%	Plan pays 80%
Chiropractic Treatment Maximum Calendar Year Benefit	Plan pays 80% $2,000 per Covered Person	

Comprehensive Medical Expense Benefits	PPO Provider	Non-PPO Provider
Infertility Treatment	Plan pays 80%	Plan pays 70%
Maximum Calendar Year Benefit		
Testing & Medical/Surgical	$5,000	
Prescription Drugs	$5,000	
Maximum Lifetime Benefits		
Testing & Medical/Surgical	$25,000	
Prescription Drugs	$25,000	
Mental and Nervous Disorders		
Precertification Non-Compliance Deductible (applies to inpatient treatment only)	$200	
Inpatient Treatment	Plan pays 80%	Plan pays 70%
Outpatient Treatment	Plan pays 80%	Plan pays 70%
Copayment	None	Covered Person pays $5 per visit
Chemical Dependency		
Precertification Non-Compliance Deductible (applies to inpatient treatment only)	$200	
Inpatient Treatment	Plan pays 80%	Plan pays 70%
Outpatient Treatment	Plan pays 80%	Plan pays 70%
All Other Covered Medical Expenses	Plan pays 80%	
Prescription Drug Benefit		
Retail Pharmacy Card (30-day supply) (Applies to short-term and acute medications)		
Brand Name and Generic	Plan pays 80% and Covered Person pays 20%	
Maintenance Choice Program (up to 90-day supply) (Applies to long-term and maintenance medications as determined by PBM)		
Copays		
Brand Name (when no generic available)	$40	
Brand Name (when generic available)	$60	
Generic	$15	
Note 1: Maintenance drugs can only be filled at the time of the initial prescription plus one refill at the retail level. After that, a Covered Person must use the Maintenance Choice Program or prescription drugs will not be covered.		
Note 2: Medications filled through the Specialty Pharmacy Program must be precertified by the PBM, otherwise the medications are not covered.		

SCHEDULE OF BENEFITS – PLAN III

Loss of Life Benefit		
Loss of Life	$6,500	
Accidental Death & Dismemberment Benefit		
(Non-occupational or non-work connected accidental death or dismemberment)		
Loss of Life	$6,500	
Loss of two hands, two feet, or sight of two eyes	$6,500	
Loss of one foot & sight in one eye, or one hand & sight in one eye, or one hand & one foot	$6,500	
Loss of one hand, one foot, or sight in one eye	$3,250	
Weekly Disability Benefit		
(Applies to non-occupational or non-work connected sickness or injury)		
Weekly Disability Benefit	$280	
Maximum Period	22 weeks	
Day disability benefits begin:		
Disability due to accidental injury	1st day	
Disability due to sickness	8th day	
Comprehensive Medical Expense Benefits		
	PPO Provider	**Non-PPO Provider**
Calendar Year Maximum	Unlimited	
Calendar Year Deductibles		
Individual	$150	
Family (3 Individual Deductibles)	$450	
Calendar Year Out-of-Pocket Maximums		
Individual	$1,000	
Family	$1,500	
Non-PPO Hospital Deductible	$250 per Covered Person for each confinement	
Non-PPO Doctor Deductible	$5 per Covered Person for each office visit with a Non-PPO Doctor	
Hospital – Inpatient and outpatient services & supplies (other than outpatient surgery)	Plan pays 80%	Plan pays 70%
Hospital Review Noncompliance Deductible (includes admissions for mental health & chemical dependency)	$200	
Second and Third Surgical Opinions (applies to non-emergency inpatient and outpatient surgeries which cost $5,000 or more when required by the Review Organization)	Plan pays 100%; Not subject to Calendar Year Deductible	
Surgery Review Program Non-Compliance Deductible	$200	
Non-emergency Outpatient Surgery (When performed in a Hospital outpatient department or in an outpatient surgical facility)		
Covered Medical Expenses incurred for facility services incurred on the date of surgery	Plan pays 80% (in a PPO Hospital and PPO Outpatient Surgical Facility)	Plan pays 70% (in a Non-PPO Hospital) No Coverage when performed in a Non-PPO Outpatient Surgical Facility
Covered Medical Expenses incurred for surgeons' services, anesthesia, radiology, pathology, drugs, and other miscellaneous services and supplies provided on the date of surgery	Plan pays 80% (in a PPO Hospital or PPO Outpatient Surgical Facility)	Plan pays 80% (in a Non-PPO Hospital) No coverage for a Non-PPO Outpatient Surgical Facility
Skilled Nursing Facility Care	Plan pays 80%	Plan pays 70%
Maximum days of confinement	90 days per Calendar Year	
Private Duty Nursing	Plan pays 80%; Not subject to Calendar Year Deductible	
Maximum Nursing Shifts	90 Shifts per Calendar Year	

Comprehensive Medical Expense Benefits	PPO Provider	Non-PPO Provider
Hospice Care Lifetime Maximum per Covered Person	Plan pays 80%	Plan pays 70%
	$10,000	
Home Care Allowance	6 hours per day (up to 24 hours per day during a period of crisis)	
Emergency Room (applies to Emergency Admission or Medical Emergency treatment)	Plan pays 80% of Covered Medical Expenses at PPO level when either a PPO or Non-PPO Hospital is used; Not subject to Calendar Year Deductible	
Emergency Room Deductible	$50 per visit	
First Aid Treatment Covered Medical Expenses incurred within first 72 hours after an injury	Plan pays 100% up to $300 Subject to the Emergency Room Deductible	
Covered Medical Expenses in excess of $300 and/or which are incurred more than 72 hours after an injury	Plan pays 80% Subject to the Calendar Year Deductible	
Routine Physical Examinations – From birth to below age 19)	Plan pays 100% Not subject to Calendar Year Deductible	
Routine Physical Examinations – Covered Persons over age 18	Plan pays 100% every 36 months; Not subject to Calendar Year Deductible	
Prostate Specific Antigen (PSA) Test and Prostate Examination (For Covered Persons age 40 or older and under age 65)	Plan pays 100% up to $150; Not subject to Calendar Year Deductible	
Gynecological Examinations (Includes up to two gynecological exams per Calendar Year, including pap smears and bilateral mammograms as well as HPV screening every 3 years for Covered Persons who are female over age 30)	Plan pays 100%; Not subject to Calendar Year Deductible	
Colorectal Cancer Screenings (Includes Covered Medical Expenses incurred for fecal occult blood tests (FOBT), sigmoidoscopies, and double contrast barium enema (DCBE) tests performed in accordance with the criteria and frequency described in the Covered Medical Expense Benefit Section)	Plan pays 80%	
Physical Therapy Maximum Number of Treatments	Plan pays 80%	
Per Calendar Year	26 per Covered Person	
Occupational Therapy Maximum benefit per Calendar Year	Plan pays 80% $5,000 per Covered Person	
Hearing Aids Every 3 calendar years	Plan pays 100% of first $500 per Covered Person	
	Plan pays 80% of balance if PPO used	Plan pays 70% of balance if non-PPO used
Diagnostic Imaging	Plan pays 100%	Plan pays 80%
Chiropractic Treatment Maximum Calendar Year Benefit	Plan pays 80% $2,000 per Covered Person	

Comprehensive Medical Expense Benefits	PPO Provider	Non-PPO Provider
Infertility Treatment	Plan pays 80%	Plan pays 70%
Maximum Calendar Year Benefit		
Testing & Medical/Surgical	$5,000	
Prescription Drugs	$5,000	
Maximum Lifetime Benefits		
Testing & Medical/Surgical	$25,000	
Prescription Drugs	$25,000	
Mental and Nervous Disorders		
Precertification Non-Compliance Deductible (applies to inpatient treatment only)	$200	
Inpatient Treatment	Plan pays 80%	Plan pays 70%
Outpatient Treatment	Plan pays 80%	Plan pays 70%
Maximum number of visits per Covered Persons	25 visits per Calendar Year	
Copayment	None	Covered Person pays $5 per visit
Chemical Dependency		
Precertification Non-Compliance Deductible (applies to inpatient treatment only)	$200	
Inpatient Treatment	Plan pays 80%	Plan pays 70%
Outpatient Treatment	Plan pays 80%	Plan pays 70%
All Other Covered Medical Expenses	Plan pays 80%	
Prescription Drug Benefit		
Retail Pharmacy Card (30-day supply) (Applies to short-term and acute medications)		
Brand Name and Generic	Plan pays 80% and Covered Person pays 20%	
Maintenance Choice Program (up to 90-day supply) (Applies to long-term and maintenance medications as determined by PBM)		
Copays		
Brand Name (when no generic available)	$40	
Brand Name (when generic available)	$60	
Generic	$15	
Note 1: Maintenance drugs can only be filled at the time of the initial prescription plus one refill at the retail level. After that, a Covered Person must use the Maintenance Choice Program or prescription drugs will not be covered.		
Note 2: Medications filled through the Specialty Pharmacy Program must be precertified by the PBM, otherwise the medications are not covered.		
Dental Benefits		
Calendar Year Maximum		
Individual	$1,500	
Family	$3,750	
Calendar Year Deductible		
Individual	$10	
Family (3 Individual Deductibles)	$30	
Routine Services	Plan pays 100% every 6 months; Deductible does not apply	
Basic Services	Plan pays 80%	
Complete Denture Replacement	Plan pays 50% once every 60 months, after 12 months of eligibility	

Orthodontia Benefit	Plan pays 50%	
Lifetime Maximum	$1,500 per Covered Person	
Periodontal Benefit	Plan pays 80%	
Lifetime Maximum	$2,000 per Covered Person	
Vision Benefit	**PPO Provider**	**Non-PPO Provider**
Standard Exam – Once every Calendar Year	Plan pays 100%	Plan pays 100% up to $30
Exam Options		
Standard Contact Lens Fit & Follow-Up	Plan pays 100% up to $40	No coverage
Premium Contact Lens Fit & Follow-Up	Covered Person pays 100% at a 10% discount on the retail price	No coverage
Frames – Once every Calendar Year	Plan pays 100% up to $100; Covered Person pays remaining amount at a 20% discount on the retail price	Plan pays 100% up to $30
Standard Plastic Lenses – Once every Calendar Year	Plan pays 100% after $5 copay for single vision lenses, $12.50 for bifocals, and $32.50 for trifocals	Plan pays 100% up to $50
Lens Options • UV Coating • Tint (solid & gradient) • Standard Scratch Resistance • Standard Polycarbonate • Standard Anti-Reflective Coating • Standard Progressive (add-on) • Other Add-ons and Services	Covered Person pays: $15 $15 $15 $40 $45 $65 Entire amount at 20% discount of retail price	Not covered
Contact Lenses – Once every Calendar Year		
Conventional Lenses	Plan pays 100% up to $100; Covered Person pays remaining amount at a 20% discount on the retail price	Plan pays 100% up to $50
Disposable Lenses	Plan pays 100% up to $100	Plan pays 100% up to $50
Medically Necessary Lenses	Plan pays 100%	Plan pays 100% up to $200

ELIGIBILITY

ELIGIBILITY FOR PLAN II AND III ACTIVE EMPLOYEES AND THEIR DEPENDENTS

The Trustees specifically reserve the right to change, reduce or eliminate any benefits provided for retirees, or initiate or increase Self-Payments for coverage, or completely terminate such coverage, at any time, and from time to time, in their sole and unrestricted discretion. (The term "Plan" includes the sub-Plans described in the SPD as Plan II or Plan III.)

You attain eligibility for Plan II or Plan III depending on the number of hours you work in Covered Employment. Your Dependents will be eligible for the Dependent benefits provided under the same Plan for which you have attained eligibility

INITIAL ELIGIBILITY REQUIREMENTS

If you are a ***new bargaining unit Employee***, you and your Dependents will become initially eligible for **Plan II** benefits if:

- You are an Employee of an Employer who makes Contributions to the Fund for you pursuant to the terms of a Collective Bargaining Agreement;
- You are not gainfully employed at work in the roofing industry other than in the craft jurisdiction of the Union;
- You are not self-employed;
- You are not an Owner or Spouse of an Owner of a Roofing Contractor; and
- You work at least 800 hours in Covered Employment during a continuous period of no more than 12 months.

If you are a ***new* apprentice or a pre-apprentice in the Illinois Valley area***, you and your Dependents will become initially eligible for **Plan II** benefits if:

- The Fund Office is notified in writing of your apprentice Employee status by the Chicagoland Roofers' Joint Apprenticeship and Training Committee (the "JATC");
- You are an Employee of an Employer who makes Contributions to the Fund for you pursuant to a Collective Bargaining Agreement;
- You have not previously worked under a Collective Bargaining Agreement;
- You are not gainfully employed at work in the roofing industry other than in the craft jurisdiction of the Union;
- You are not self-employed;
- You are not an Owner or Spouse of an Owner of a Roofing Contractor;
- You are participating in a training program arranged by the JATC; and

- You work at least 600 hours in Covered Employment during a continuous period of no more than 12 months.

You are considered to be an apprentice Employee, as defined in the Collective Bargaining Agreement, if you are an individual who has entered into a training program arranged by the JATC.

If you are a ***new* post-apprentice or journeyman,*** you and your Dependents will become initially eligible for Plan II benefits if:

- You are an Employee of an Employer who makes Contributions to the Fund for you pursuant to a Collective Bargaining Agreement;
- You have not previously worked under a Collective Bargaining Agreement;
- You are not gainfully employed at work in the roofing industry other than in the craft jurisdiction of the Union;
- You are not self-employed;
- You are not an Owner or Spouse of an Owner of a Roofing Contractor; and
- You work at least 300 hours in Covered Employment during a period of no more than 12 consecutive months.

You are considered to be a new post-apprentice Employee or journeyman Employee if you meet the definitions found in the Collective Bargaining Agreement.

If you are a full-time ***Employee of the Union, Chicagoland Roofers' Joint Apprenticeship and Training Fund or the Fund*** who is not employed in a collective bargaining unit represented by the Union and who is regularly scheduled to work 30 or more hours per week (referred to as a "Non-Bargaining Unit Employee"), you and your Dependents will become eligible for **Plan II** benefits to begin on the 61st day of continuous employment.

Special rules apply to Owners (and Spouses) of Roofing Contractors. See the section entitled *Initial and Continuing Eligibility for Owners and Spouses of Owners of Roofing Contractors.*

* You will not qualify as "new" if a Contribution has ever been made to this Fund on your behalf. An Employee who was formerly represented for collective bargaining purposes by a local union affiliated with the Roofers International Union and who transferred into the geographic jurisdiction of the Union will not be considered "new."

INITIAL ELIGIBILITY - WHEN BENEFITS START (All Plan II and III Employees)

Coverage will begin for you and your Dependents on the first day of the second month following the date on which you meet the initial eligibility requirements. For non-bargaining unit employees and their dependents coverage begins on the 61st day of continuous employment. Dependent benefits for a person who becomes your Dependent while you are already eligible will begin when the person becomes your Dependent if you enroll your new Dependent in a timely manner. Your enrolled Dependents will be covered under the Plan for which you are eligible.

Enrolling a Dependent - New family members who meet the definition of a Dependent must be enrolled within 12 months of the date a new Spouse or Child is acquired for coverage to be effective as of the date the Dependent was acquired. Enrollment consists of providing a completed and signed enrollment form and the following documents to the Fund Office:

1. For a Spouse, a certified copy of the marriage certificate and verification of their Social Security number.

2. For a natural Child, a certified copy of the birth certificate and verification of their Social Security number.

3. For a stepchild, a certified copy of the Child's birth certificate, verification of their Social Security number and a certified copy of the divorce decree and/or custody agreement showing that the Spouse of the Eligible Employee (or Eligible Retiree) has custody of the Child (and who is responsible for the Child's health care expenses).

4. For other Children, a certified copy of the birth certificate, verification of their Social Security number and a certified copy of the court or paternity order, a Qualified Medical Child Support Order (QMCSO), or evidence acceptable to the Fund that the Child has been placed in the care of the Eligible Employee (or Eligible Retiree) for adoption.

After you meet the initial eligibility requirements, you and your Dependents are eligible for Plan II benefits for the remainder of the Calendar Year in which you first become eligible for coverage and for all of the following Calendar Year. If you are credited with at least 1,300 hours of work in Covered Employment during the Contribution Period (October 1 – September 30), you and your Dependents will be eligible for Plan II benefits for the remainder of the Calendar Year in which you initially become eligible and for Plan III benefits in the Calendar Year immediately following the Calendar Year in which you became initially eligible.

Example:

Kevin, a bargaining unit Employee, begins working and has more than 800 hours in Covered Employment between October 1, 2013 and June 30, 2014.

- **Initial Eligibility Coverage Period:** Kevin is eligible for Plan II coverage from August 1, 2014 through December 31, 2015, which is the remainder of his initial Calendar Year of eligibility and all of the following Calendar Year.

- **Initial Eligibility Plan Coverage:** If Kevin has:

- Less than 1,300 hours in Covered Employment between October 1, 2013 and September 30, 2014, he will be covered under Plan II from August 1, 2014 through December 31, 2015.

- 1,300 or more hours in Covered Employment between October 1, 2013 and September 30, 2014, he will be covered under:
    - Plan II from August 1, 2014 through December 31, 2014 (his initial Calendar Year of eligibility); and
    - Plan III from January 1, 2015 through December 31, 2015 (the following Calendar Year).

CONTINUING ELIGIBILITY (All Plan II and III Employees)

Starting on January 1 of each Calendar Year, you are eligible for continued coverage only if:

- You have met the initial eligibility requirements for Plan II.
- You were eligible for either Plan II or Plan III benefits during the immediately preceding Calendar Year;
- You are not self-employed;
- You are not working as an Owner or Spouse of an Owner of a Roofing Contractor;
- You are not gainfully employed at work in the roofing industry other than in the craft jurisdiction of the Union; and
- You are credited, during the Contribution Period (October 1 through September 30) with at least 900 but less than 1,300 hours of work in Covered Employment, from credited Disability Hours, or from Self-Payment hours, or a combination of such hours. You will be eligible for Plan II benefits for the following Calendar Year, or
- You are credited, during the Contribution Period (October 1 through September 30) with at least 1,300 hours of work in Covered Employment, from credited Disability Hours, or from Self-Payment hours, or a combination of such hours. You will be eligible for Plan III benefits for the following Calendar Year
- **Exception**: If you were eligible for Plan II benefits in the prior Calendar Year, you cannot use Disability Hours or Self-Payment hours to become eligible for Plan III.

Example:

If Kevin has 1,300 or more hours in Covered Employment between October 1, 2013 and September 30, 2014, he will be covered under Plan III for the 2015 Calendar Year.

If you are in Plan II and you work enough hours during the Contribution Period (October 1 through September 30) to meet the requirements for Plan III, your benefits for the following Calendar Year will be upgraded to Plan III.

If you are in Plan III during a Calendar Year and earn less than 1,300 hours during the Contribution Period (October 1 through September 30) but you have at least 900 hours, your benefits for the following Calendar Year will drop down to Plan II unless you are entitled to make a Regular Self-Payment and do so.

If you earn less than 900 hours during the Contribution Period (October 1 through September 30), your eligibility for benefits will terminate at the end of that Calendar Year unless you are entitled to make and do make an on-time Regular Self-Payment or COBRA Payment.

SPECIAL RULE FOR NON-BARGAINING UNIT EMPLOYEES

Starting on January 1 of each Calendar Year, you are eligible for continued coverage only if:

- You have met the initial eligibility requirements for a Non-Bargaining Unit Employee. Once you have met the initial eligibility requirements for Plan II benefits, then your eligibility for a Plan of benefits will be determined as follows:
    - If you were hired during the last six months of a Calendar Year, you and your Dependents will be remain eligible for Plan II benefits during the following Calendar Year; or
    - If you were hired during the first six months of a Calendar Year, the Plan of benefits for which you and your Dependents will be eligible for in the following Calendar Year will be determined by the number of hours of Covered Employment you have during the Calendar Year in which you were hired.
- For all succeeding Calendar Years subject to the Termination of Employee Eligibility rule:
    - You must have been eligible for either Plan II or Plan III benefits during the previous Calendar Year;
    - The Plan for which you and your Dependents will be covered shall be determined by the following hours requirements:
        - For Plan II if, during the preceding Calendar Year, you accumulated at least 900 hours but less than 1,300 hours from work in Covered Employment; or
        - For Plan III benefits if, during the preceding Calendar Year, you accumulated at least 1,300 hours from work in Covered Employment.

ELIGIBILITY FOR PLAN II-PA ACTIVE EMPLOYEES

The Trustees specifically reserve the right to change, reduce or eliminate any benefits provided for retirees, or initiate or increase Self-Payments for coverage, or completely terminate such coverage, at any time, and from time to time, in their sole and unrestricted discretion. (The term "Plan" includes the sub-Plan described in the SPD as Plan II-PA.)

You attain eligibility for Plan II-PA depending on the number of hours you work in Covered Employment.

INITIAL ELIGIBILITY REQUIREMENTS

If you are a Pre-Apprentice other than in the Illinois Valley area, you will become initially eligible for **Plan II-PA** benefits if:

- You are an Employee of an Employer who makes Contributions to the Fund for you pursuant to the terms of a Collective Bargaining Agreement;
- You are not gainfully employed at work in the roofing industry other than in the craft jurisdiction of the Union;
- You are not self-employed;
- The Fund Office is notified in writing of your Pre-Apprentice status by Local No. 11;
- You are not an Owner or Spouse of an Owner of a Roofing Contractor; and
- You work at least 300 hours in Covered Employment during a continuous period of no less than 3 months and in no more than 12 months.

INITIAL ELIGIBILITY - WHEN BENEFITS START (All Plan II-PA Employees)

Coverage will begin for you on the first day of the month following the date on which you meet the initial eligibility requirements. There is no coverage for your Dependents under Plan II-PA.After you meet the initial eligibility requirements, you are eliglble for Plan II-PA benefits for the remainder of the Calendar Year in which you first become eligible for coverage.

Example:

Paul, a Pre-Apprentice, begins working and has more than 300 hours in Covered Employment between October 1, 2013 and June 30, 2014.

- **When Coverage Starts:** Paul becomes eligible for Plan II-PA coverage on July 1, 2014 because he has met the initial eligibility hours requirement of at least 300 hours in Covered Employment during a continuous period of no less than 3 but no more than 12 months as a Pre-Apprentice.

- **Initial Eligibility Coverage Period:** Paul is eligible for Plan II-PA coverage from July 1, 2014 through December 31, 2014, which is the remainder of his initial Calendar Year of eligibility.

CONTINUING ELIGIBILITY (All Plan II-PA Employees)

Starting on January 1 of each Calendar Year, you are eligible for continued coverage only if:

- You have met the initial eligibility requirements for Plan II-PA.
- You were eligible for Plan II-PA benefits during the immediately preceding Calendar Year;
- You are not self-employed;
- You are not working as an Owner or Spouse of an Owner of a Roofing Contractor;
- You are not gainfully employed at work in the roofing industry other than in the craft jurisdiction of the Union; and
- You are credited, during the Contribution Period (October 1 through September 30) with at least 900 hours of work in Covered Employment or from credited Disability Hours, or a combination of such hours, you will be eligible for Plan II-PA benefits for the following Calendar Year.

Example:

Paul gained initial eligibility July 1, 2014 and was eligible for Plan II-PA coverage until December 31, 2014. He has 900 hours in Covered Employment from October 1, 2013 through September 30, 2014. He will be covered under Plan II-PA for the 2015 Calendar Year.

If at any time a Pre-Apprentice is accepted into the Chicagoland Roofers' Joint Apprenticeship and Training Committee (JATC) Apprenticeship Program, eligibility rules for a new Apprentice then apply. Eligibility for Plan II-PA benefits will continue until you either meet the eligibility requirements for a new Apprentice or you no longer meet the eligibility rules for Plan II-PA coverage.

NOTE: Only hours you work after you are accepted into the Apprenticeship Program will count toward meeting the 600 hour requirement for Plan-II benefits. None of the hours worked prior to your acceptance into the Apprenticeship Program will count toward Plan II coverage.

ELIGIBILITY FOR OWNERS AND SPOUSES OF OWNERS OF ROOFING CONRACTORS

INITIAL AND CONTINUING ELIGIBILITY FOR OWNERS AND SPOUSES OF OWNERS OF ROOFING CONTRACTORS

There are special rules for determining eligibility for Owners and Spouses of Owners of Roofing Contractors in all areas except the Illinois Valley area.

In order to be eligible for benefits in 2015, based on collective bargaining unit work performed in 2014, the Board of Trustees has determined that each Owner Participant must have contributions paid to the Fund by a Roofing Contractor for the actual number of hours worked in Covered Employment, but no fewer than 1,300 hours in a Calendar Year for initial eligibility and continuing eligibility for Plan II coverage and no fewer than 1,700 hours for Plan III coverage for continuing eligibility only. Such contributions must be paid at the contribution rate required from time to time under the Collective Bargaining Agreements.

If an Owner Participant also performs collective bargaining work for a Roofing Contractor in which he is not an owner, those hours worked will be considered independently to establish eligibility for coverage under either Plan II or Plan III, as applicable. If the Owner Participant does not have a sufficient number of these hours to establish eligibility for Plan II or Plan III, the Owner Participant may use a combination of hours (worked for a Roofing Company in which he is not an Owner and for a Roofing Contractor in which he is an Owner) to satisfy the Owner Participant threshold for eligibility.

For initial eligibility and continuing eligibility, if you are an Owner Participant for whom 1,300 but less than 1,700 hours of Contributions are made to the Fund in a Calendar Year, you and your Dependents will be eligible for Plan II coverage. For continuing eligibility only, if you are an Owner Participant for whom 1,700 or more hours of Contributions are made to the Fund, you and your Dependents will be eligible for Plan III coverage. Unless such Contributions are received, an Owner Participant will not be eligible for any other type of health coverage under the Fund.

The Board of Trustees determines each year whether to offer coverage to Owners and Spouses of Owners of Roofing Contractors and if such coverage is offered they determine the eligibility terms, including the number of hours that must be contributed to obtain coverage.

ELIGIBILITY FOR ACTIVE EMPLOYEES - OTHER PROVISIONS

ELIGIBILITY DURING DISABILITY

If you meet the requirements for receiving Disability Hours as described below, you will be covered to the end of the Calendar Year under the Plan you were covered under when you became Totally Disabled. If the Disability Hours you receive are sufficient to provide eligibility for the following Calendar Year, you will be eligible for coverage during the subsequent Calendar Year also. You will be credited with five Disability Hours for each day (Monday through Friday) you are Totally Disabled up to a maximum of 25 Disability Hours per calendar week. You will be credited with Disability Hours up to a maximum of 1,300 for a Period of Total Disability. However, your Disability Hours cannot place you in Plan III if you were in Plan II when your Total Disability started.

To be eligible to receive Disability Hours, you must:

1. be totally prevented from performing each and every duty of your normal occupation or employment as a result of an occupational or non-occupational accidental bodily injury or sickness; and

2. not be engaged in any occupation, employment or activity, including self-employment for remuneration, wages or profit; and

3. submit an Attending Physician's Statement every three months certifying your inability to work at the craft if the injury is not work-related or submit all temporary total disability check stubs from the Workers' Compensation Carrier; and

4. be covered under the Plan.

To be **Totally Disabled** means that you are totally prevented from performing each and every duty of your normal occupation or employment as a result of non-occupational injury or sickness and are not performing or engaging in any occupation or employment for wage, remuneration, or profit.

A **Period of Total Disability** means successive periods of Total Disability resulting from or contributed to by the same or related cause unless the second Period of Total Disability commences after you have returned to active full-time employment for a Contributing Employer for at least five consecutive days for which hours were contributed. Successive Periods of Total Disability separated by less than five consecutive days for which hours were contributed will be considered one Period of Total Disability unless the second Total Disability is due to an accidental injury or sickness which is entirely unrelated to the cause or causes of the previous Total Disability and begins after you have returned to active full-time employment for a Contributing Employer for one 8 hour day.

WORKING AT THE CRAFT OUTSIDE LOCAL NO. 11 JURISDICTION

If you are covered under the Plan and transfer to another Local Union affiliated with the International Union of Roofers, Waterproofers and Allied Workers, you will continue to be covered under the Plan you

were in when you left the Local No. 11 jurisdiction. You will be covered until you become eligible under your new Local's welfare fund or to the end of the 6-month period after you leave Local No. 11's jurisdiction, whichever occurs first.

SPECIAL ENROLLMENT FOR PLANS II AND III

You and your Dependents may be eligible for a special enrollment if:

- You and/or your Dependents decline coverage under this Plan because you have other health coverage and then you and/or your Dependents later lose the other health coverage; or
- You acquire a Dependent through marriage, birth, adoption, or placement for adoption.

For special enrollments due to loss of other coverage, you or your Dependent must:

- Otherwise be eligible for Plan coverage; and
- Have been covered under another group health plan or other health insurance when coverage under this Plan was declined, and enrollment must have been declined due to such other coverage.

If the other health coverage was COBRA Continuation Coverage, a special enrollment is only available after the COBRA Continuation Coverage has been exhausted. If the other coverage is not COBRA Continuation Coverage, a special enrollment is available if you or your Dependent is no longer eligible for coverage or for employer contributions for the other coverage.

To enroll yourself and/or your Dependent, you will need to complete, sign, and submit an enrollment form to the Fund Office. You will also need to provide proof of Dependent status if applicable. Coverage will become effective once the Fund Office approves the enrollment form and any requested documentation of Dependent status.

If you are enrolling yourself and/or your Dependents (including your Spouse) after other health coverage ends, coverage will become effective on the date you and/or your Dependents lose the other health coverage if you (or your Dependents) enroll within 12 months after the date you and/or your Dependents lose other health coverage. If enrollment occurs more than 12 months after the date you and/or your Dependents lose other health coverage, your coverage becomes effective on the date the Fund Office receives the completed enrollment form and proof of Dependent status acceptable to the Fund Office.

Coverage of a new Spouse, a newborn Child, a newly adopted Child, or a Child placed for adoption who is enrolled within 12 months after the date of marriage, birth, adoption, or placement for adoption will become effective as of the date of marriage, birth, adoption, or placement for adoption. If enrollment occurs more than 12 months after you acquire a new Dependent, the Dependent's coverage will become effective on the date that you submit a completed enrollment form and proof of Dependent status that is acceptable to the Fund Office.

Special enrollments are not available for loss of coverage due to failure to pay premiums, fraud, or misrepresentation.

TERMINATION OF EMPLOYEE ELIGIBILITY

Your eligibility under the Plan will terminate at 11:59 p.m. on the first to occur of the following:

1. The date the Trustees terminate either the Plan or the Plan of Benefits under which you are then covered.

2. The date you become an active member of the military service or armed forces of any country except as otherwise may be required under USERRA or similar law.

3. If you are making COBRA payments, at the end of the last day of the last month of the applicable maximum coverage period to which you were entitled and for which correct and on-time COBRA payments were made or on the date of occurrence of any of the events stated in the section *When COBRA Continuation Coverage Ends* whichever occurs first.

4. **For Plan II, II-PA and III Employees:**

   a. On December 31 of any Calendar Year during which you fail to accumulate the hours required to continue Plan coverage from working in Covered Employment, from credited Disability Hours, from Regular Self-Payments (for Plan II and III Employees), or a combination of such hours;

   b. The date you fail to meet all of the other requirements for continuing eligibility;

   c. The date you retire unless you are eligible for continued Plan II benefits as an Eligible Retiree; or

   d. With respect to Totally Disabled Employees:

      i. If you are Totally Disabled on December 31 of the Calendar Year in which you fail to accumulate at least 900 Disability Hours, or Disability Hours and Regular Self-Payment hours (for Plan II and III employees.)

      ii. If you are Permanently and Totally Disabled, on December 31 of the Calendar Year in which you fail to accumulate at least 900 Disability Hours, or Disability Hours and Regular Self-Payment hours (for Plan II and III employees)

   e. The last day of the month in which employment terminates for a Non-Bargaining Unit Employee.

REGULAR SELF-PAYMENTS FOR PLAN II AND PLAN III

If you have not accumulated enough hours during the applicable Contribution Period from working in Covered Employment and/or from Disability Hours to stay eligible during the next Calendar Year in the Plan for which you are currently eligible (either Plan II or Plan III), you may be able to make a Regular Self-Payment to continue your eligibility. If you are not eligible to or you do not make a Regular Self-Payment, you may be entitled to elect COBRA Continuation Coverage.

The Regular Self-Payment amount required is an hourly amount multiplied by the maximum number of hours which can be self-paid to continue coverage as determined by the Trustees from time to time, plus a special service charge for the privilege of making a Regular Self-Payment. The special service charge is in addition to the amount of the Regular Self-Payment and must be paid at the same time you make the Regular Self-Payment. The terms of the Regular Self-Payment program are determined from time to time by the Trustees and may be modified, or eliminated pursuant to the sole and unrestricted discretion of the Trustees.

If you do not pay the full amount of the Regular Self-Payment plus the special service charge on or before the due date set forth in the Regular Self-Payment notice, you forfeit your right to make the payment and may not make the payment at a later date.

REGULAR SELF-PAYMENT RULES (PLANS II AND III)

The following rules apply to Regular Self-Payments:

1. You cannot make a Regular Self-Payment to earn initial eligibility.

2. Owner Participants cannot make Regular Self-Payments.

3. You must be eligible for Plan II or Plan III on December 31 of a Calendar Year in order to make a Regular Self-Payment to continue coverage for the next following Calendar Year.

4. After the Fund Office receives the Employer Contribution reports for the Contribution Period (October 1 through September 30) the Fund Office will determine whether you need to make a Regular Self-Payment to continue your coverage. If you need to make a Regular Self-Payment, the Fund Office will send you a notice, with the amount of your Regular Self-Payment. The notice will state the due date for your payment and the address to which your payment should be sent.

5. The number of hours for which you can make a Regular Self-Payment for coverage under Plan II and Plan III is determined by the Trustees and is subject to change each Calendar Year.

6. If you do not pay the entire Regular Self-Payment amount on or before the due date shown on the notice, you cannot make the payment at a later time. A Regular Self-Payment will be considered on time if it is delivered or mailed by the due date. (Postmarks affixed by the U.S. Postal Service will be considered proof of date of mailing. Postage meter imprints or any other evidence of mailing date, including date imprints by overnight courier services such as UPS, will not be considered proof of date of mailing unless payment is actually delivered to the Fund Office no later than the first business day immediately following the mailing date shown.)

> While the Fund Office will attempt to send a Regular Self-Payment notice to your last address on file at the Fund Office, the Fund does not guarantee that it will do so or that you will receive it. You are responsible for determining whether you will be required to make a Regular Self-Payment to continue your coverage, to determine the amount of your Self-Payment, for finding out what the due date for the payment is, and for making any required payment by the due date. If you do not receive a notice by December 15, *you are responsible* for calling the Fund Office to determine the status of your eligibility.

The Regular Self-Payment rules as of the effective date of this SPD are as follows:

PLAN II REGULAR SELF-PAYMENT RULES: In addition to the Regular Self-Payment rules above, the following rules apply to Regular Self-Payments for Plan II benefits:

1. You may make Regular Self-Payments to continue eligibility for Plan II benefits during the following Calendar Year only if you were eligible for Plan II or Plan III benefits during the Calendar Year.

2. In order to make a self-payment, you must have accumulated at least 550 hours but less than 850 hours from work in Covered Employment and/or from credited Disability Hours during the current Contribution Period. The Regular Self-Payment you will be required to pay will be an amount equal to the hourly rate as determined by the Trustees from time to time multiplied by the difference between the number of hours you accumulated, and 850 hours. In addition, the special service charge has been waived for this year.

3. If you are eligible for Plan III benefits during a Calendar Year, you may make a Regular Self-Payment for Plan II Benefits for the following Calendar Year if you have accumulated at least 550 hours but less than 850 hours from work in Covered Employment and /or from credited Disability Hours during the current Contribution Period. The Regular Self-Payment you will be required to pay will be an amount equal to the hourly rate as determined by the Trustees from time to time multiplied by the difference between the number of hours you accumulated and, 850 hours. In addition, the special service charge has been waived for this year.

4. If you are making a Regular Self-Payment for Plan II benefits, you may not pay for more than 300 hours.

Example:

Kevin is currently eligible for Plan II coverage. He has 750 hours in Covered Employment during the Contribution Period October 1, 2013 through September 30, 2014. He will need to make a Regular Self-Payment for 100 hours in order to continue his Plan II coverage for the 2015 Calendar Year.

PLAN III REGULAR SELF-PAYMENT RULES: In addition to the Regular Self-Payment rules above, the following rules apply to Regular Self-Payments for Plan III benefits:

1. You may make Regular Self-Payments to continue eligibility for Plan III benefits during the following Calendar Year only if you were eligible for Plan III benefits during the Calendar Year.

2. In order to make a self-payment, you must have accumulated at least 900 hours but not less than 1,300 hours from work in Covered Employment and/or from credited Disability Hours during the current Contribution Period. The Regular Self-Payment you will be required to pay will be an amount equal to the hourly rate as determined by the Trustees from time to time multiplied by the difference between the number of hours you accumulated and 1,300 hours. The special service charge has been waived for this year.

3. If you are making Regular Self-Payments for Plan III benefits, you may not pay for more than 400 hours.

Example:

Steve is currently eligible for Plan III coverage. He has 985 hours in Covered Employment during the Contribution Period October 1, 2013 through September 30, 2014. He will need to make a Regular Self-Payment for 315 hours in order to continue his Plan III coverage for the 2015 Calendar Year. If he does not make the Regular Self-Payment, he will be eligible for Plan II coverage for the 2015 Calendar Year.

RETURN TO COVERED EMPLOYMENT

RETURN AFTER TERMINATION OF ELIGIBILITY

If you are covered under the Plan and are not an Owner Participant, and your eligibility terminates and you later return to Covered Employment, you and your Dependents will become eligible for Plan II benefits on the first day of the month following the month in which you earned 900 hours from working in Covered Employment in a continuous period of at least 6 consecutive months and in no more than 12 consecutive months. If you are an Owner Participant, you must have contributions paid to the Fund by a Roofing Contractor for the actual number of hours worked in Covered Employment but no fewer than 1,300 hours in a Calendar Year, which is subject to change as determined by the Trustees from time to time.

AFTER WORKING FOR A NON-CONTRIBUTING GOVERNMENTAL OR QUASI-GOVERNMENTAL ENTITY

If you are covered under the Plan and you leave Covered Employment to work for a governmental or quasi-governmental entity that is not required to make Contributions to the Fund for you, your coverage will be reinstated on the day you return to Covered Employment if you return to Covered Employment by no later than December 31 of the Calendar Year following the Calendar Year you left Covered Employment to work for the non-contributing entity. When your coverage is reinstated, you will be covered under the Plan you were covered under when you left.

RETURN AFTER MILITARY SERVICE

If you leave employment with a Contributing Employer to enter active duty in the uniformed services of the United States, your eligibility will be frozen during your active duty and your family will be offered COBRA Continuation Coverage. After your release from active duty under circumstances entitling you to reemployment under federal law, your eligibility will be reinstated on the date you return to work with a Contributing Employer, provided you return to work within the time prescribed by USERRA and other applicable federal laws.

TERMINATION OF DEPENDENT ELIGIBILITY (Plan II and III only)

Eligibility under the Plan for a Dependent will terminate at 11:59 p.m. on the first to occur of the following dates:

1. The date the Trustees terminate either the Plan of Benefits for Dependents or the Plan under which you and your Dependents are covered;

2. The date the Dependent becomes an Eligible Employee under the Plan;

3. The date your eligibility for a particular Plan terminates for reasons other than your death or eligibility to participate in Medicare;

4. For a Child, the date the Child fails to meet the Plan's definition of a Dependent;

5. For your Spouse, the date of your divorce;

6. If you die while eligible and if you are Pension-Vested at the time of your death;

a. For your surviving Spouse, the earlier of the date he or she remarries or becomes eligible to participate in Medicare due to reaching age 65; or

b. The end of the Calendar Year following the Calendar Year in which you die, unless your surviving Spouse makes correct and timely Dependent Self-Payments for continued coverage for himself or herself and/or any other Dependents; or

c. If your surviving Spouse is continuing coverage for himself or herself and/or any other Dependents by making Dependent Self-Payments:

i. For your surviving Spouse, the earlier of the date he or she remarries or becomes eligible to participate in Medicare due to reaching age 65. (However, if your Spouse continues to make the Dependent Self-Payments, coverage for any Children will continue until the Child fails to meet the Plan's definition of a Dependent).

ii. For your surviving Spouse and any other Dependents, at the end of the period for which he or she has already made a correct and timely Dependent Self-payment if he or she fails to make a payment on or before the date it is due;

7. If you die while eligible, and if you are not Pension-Vested at the time of your death:

a. The end of the 12-month period following the month in which you die; or

b. For your surviving Spouse only, the earlier of the end of the 12-month period following the month in which you die, or if earlier, the date he or she remarries or becomes eligible to participate in Medicare due to reaching age 65.

8. If COBRA payments are being made by or on behalf of a Dependent, at the end of the last day of the last month of the applicable maximum COBRA coverage period to which the Dependent was entitled, and for which current and on-time COBRA payments were made, or on the date of occurrence of any of the events stated in *Termination of COBRA coverage*, whichever occurs first.

BENEFITS FOR DEPENDENTS OF DECEASED ELIGIBLE EMPLOYEES

If you die while you are covered under the Plan, your surviving Dependents will be entitled to benefits as follows:

SURVIVING DEPENDENTS OF DECEASED ELIGIBLE PENSION-VESTED EMPLOYEES

If you are Pension-Vested, but not entitled to a pension benefit from the Roofers' Pension Plan at the time of your death, your Dependents' coverage after your death will be continued:

1. **For the remainder of the Calendar Year in which your death occurs**: Your Dependents will continue coverage under the same Plan for which you were eligible at the time of your death without any Dependent Self-Payment to the Fund.

2. **For the Calendar Year following the Calendar Year in which your death occurs:** Your Dependents will have coverage under the Comprehensive Medical Expense Benefit and the Prescription Drug Program (but not dental, orthodontia, periodontal or vision benefits), under the same Plan for which you were eligible at the time of your death without any Dependent Self-

Payment to the Fund. If your surviving Spouse remarries or becomes eligible to participate in Medicare due to reaching age 65 during that Calendar Year, his or her benefits will terminate upon the date of his or her remarriage or the date he or she is eligible to participate in Medicare, but benefits for any Children will be continued to the end of that Calendar Year.

When coverage for the Comprehensive Medical, Dental (including orthodontia and periodontal) and vision benefits terminate at the end of the Calendar Year in which you die, your Dependents may be entitled to make COBRA Payments instead of taking the coverage explained in this Item 2 and Item 3 below. If they do elect COBRA Continuation Coverage, they permanently reject the free Comprehensive Medical Expense Benefit and Prescription Drug Program coverage explained in this Item 2 and lose their right to make Dependent Self-Payments later, as explained in Item 3 below.

3. **For succeeding Calendar Years:** Your surviving Spouse and Children are entitled to make Dependent Self-Payments to the Fund to continue coverage under the Comprehensive Medical Expense Benefit and the Prescription Drug Program under Plan II. If your surviving Spouse remarries or becomes eligible to participate in Medicare due to becoming age 65, his or her Plan benefits terminate on the date of his or her remarriage or on the date he or she becomes eligible to participate in Medicare, but he or she may still make Dependent Self-Payments according to the *Self-Payments by Dependents of Deceased Eligible Employees* rules below to continue coverage for any Children until their benefits terminate according to the termination rules.

SELF-PAYMENTS BY DEPENDENTS OF DECEASED ELIGIBLE EMPLOYEES

The terms of the Dependent Self-Payment program are determined from time to time by the Trustees and may be modified or eliminated pursuant to the sole and unrestricted discretion of the Trustees.

The Fund Office will notify your surviving Dependents how much the monthly Dependent Self-Payments are and the Dependent Self-Payment due dates. The amount of the monthly Dependent Self-Payments will be determined by the Trustees annually.

- The first Dependent Self-Payment must be made on or before the first day of the month following the date that benefits would normally terminate for your Dependents. All succeeding Dependent Self-Payments must be made on or before the first day of each month.

- If a Dependent fails to make a correct and on-time Dependent Self-Payment, that Dependent's eligibility will terminate at the end of the period for which he/she was eligible and he/she may not make any future Dependent Self-Payments.

SURVIVING DEPENDENTS OF DECEASED ELIGIBLE NON-PENSION-VESTED EMPLOYEES

If you are not Pension-Vested at the time of your death, your Dependents will be covered for 12 months starting on the first day of the month following the month in which you die, as follows:

- They will continue eligibility for Dependent benefits under the same Plan you were in at the time of your death to the end of that Calendar Year. At the end of the Calendar Year in which you die, instead of taking the free Comprehensive Medical Expense Benefit and Prescription Drug Program coverage for any remaining portion of the 12-month period following your death, your Dependents may be entitled to elect COBRA Continuation Coverage at their option. Your surviving Dependents should carefully compare the benefits coverage, length of coverage, and the cost of coverage before making a choice.

- In the next Calendar Year, your Dependents will only be entitled to the Comprehensive Medical Expense Benefits and Prescription Drug Program under that same Plan until the end of the month in which you died during the previous Calendar Year. For example, if you are covered under Plan II and die on July 15, your Dependents will continue eligibility for Dependent benefits under Plan II through December of that Calendar Year. They will then be entitled to only the Comprehensive Medical Expense Benefits and Prescription Drug Program under Plan II until July 31 of the next Calendar Year.

- Your surviving Spouse's benefits will terminate upon his or her remarriage or he or she becoming eligible to participate in Medicare due to attaining age 65 during this 12-month continuation of benefits, but benefits for any Children will be continued as stated above.

- A surviving Dependent of a non-Pension Vested employee may not make Dependent Self-Payments to continue coverage.

ELIGIBILITY AND BENEFITS FOR RETIREES AND THEIR DEPENDENTS

The Trustees specifically reserve the right to change, reduce, or eliminate any benefits provided for retirees, or initiate or increase Self-payments for coverage, or completely terminate such coverage, at any time, and from time to time, in their sole and unrestricted discretion. Retiree coverage under the Plan is not an "accrued" or "vested" benefit. The term "Plan" includes the sub-Plans described in the SPD as Plan II, Plan II-PA and Plan III.

Retirees are not eligible for the Weekly Disability Benefit or the Accidental Death and Dismemberment Benefit. In addition, the only Retirees who are eligible for the Loss of Life Benefit are those who are on disability retirement and who qualify under the *Continuation of Loss of Life Benefit During Permanent and Total Disability* rules.

ELIGIBILITY FOR RETIREE BENEFITS

You and your Dependents will be entitled to Plan benefits, as explained below if you are an "Eligible Retiree" and the Dependent is a "Dependent" as defined below:

Eligible Retiree: You are an "Eligible Retiree" if:

1. You are under age 65; and

2. You are eligible to receive early, normal or disability benefits under the Roofers' Pension Fund.

Dependent: Your Dependents are eligible for Plan benefits if the Dependents:

1. Are under age 65; and

2. Continue to meet the Plan's definition of Dependent.

Special Enrollment: If you have a new Dependent due to marriage, birth, adoption, or placement for adoption, you will be able to enroll your new Dependent if you complete and sign an enrollment form and provide the Fund Office with proof of Dependent status. The Fund Office must approve the enrollment form and proof of Dependent status before your new Dependent's coverage can become effective.

Coverage for your new Spouse, newborn Child, adopted Child, or Child placed for adoption will become effective as of the date of marriage, birth, adoption, or placement for adoption if you submit the completed enrollment form and proof of Dependent status to the Fund Office within 12 months of the date you acquired the new Dependent. If you provide the Fund Office with a completed enrollment form and proof of Dependent status more than 12 months after you acquire the Dependent, the Dependent's coverage will be effective on the date the Fund Office receives the completed enrollment form and proof of Dependent status.

EARLY RETIREMENT (Retirement at Ages 55 Through 59)

Although the early retirement age under the Roofers' Pension Plan is age 55 through age 64, if you are an "Eligible Retiree" who is at least age 55 but under age 60, you and your Dependents will be entitled to

benefits according to the applicable provisions explained below. Special rules apply if you are at least age 58 but less than age 60 and retire with an Early Retirement Pension with 30 years of credited service. See the *Normal Retirement* section below.

BENEFIT COVERAGE AT EARLY RETIREMENT

If you are an Eligible Retiree, Plan coverage for you and any Dependents will be as follows:

- ***For the remainder of the Calendar Year in which you retire***, you will continue to be eligible for the Plan you were covered under on the date of your retirement.

- ***For the Calendar Year following the Calendar Year in which you retire***, the Plan for which you and your Dependents will be eligible will be determined by the hours you earn during the Calendar Year in which you retire (see Hours Requirement below) provided there is no break in your coverage between the active Plan coverage and your retirement.

  Hours Requirement: The Plan for which you will be eligible in the Calendar Year following the Calendar Year in which you retire will be based on the number of hours you worked in Covered Employment, credited Disability Hours, and Self-Payment Hours, or a combination of all those hours in the Calendar Year you retire as follows:

  - Plan II: At least 900 hours but less than 1,300 hours.

  - Plan III: 1,300 or more hours.

NORMAL RETIREMENT (Retirement at Ages 60 Through 64)

Although the "normal" retirement age under the Roofers' Pension Plan is age 65, if you are an "Eligible Retiree" between the ages of 60 through 64, you and your Dependents will be entitled to benefits according to the applicable provisions explained below.

SPECIAL EARLY RETIREMENT (Retirement at Ages 58 Through 59)

If you are at least age 58 but less than age 60 and retire with an Early Retirement Pension with 30 years of credited service, you and your Dependents will be entitled to benefits according to the applicable provisions explained in the *Normal Retirement* section below provided you have authorized the Roofers' Pension Fund to remit the Social Security Supplement to the Roofers' Unions Welfare Trust Fund until you attain age 60.

BENEFIT COVERAGE AT NORMAL RETIREMENT AND SPECIAL EARLY RETIREMENT

If you are an Eligible Retiree, Plan coverage for you and any Dependents will be as follows:

- ***For the remainder of the Calendar Year in which you retire,*** you will continue to be eligible for the Plan you were covered under on the date of your retirement.

- ***For the Calendar Year following the Calendar Year in which you retire***, the Plan for which you and your Dependents will be eligible will be determined by:

1. The hours you work in Covered Employment during the Calendar Year in which you retire (See Hours Requirement Below), provided there is no break in your coverage between the active Plan coverage and your retirement; or

Hours Requirement: The Plan for which you will be eligible in the Calendar Year following the Calendar Year in which you retire will be based on the number of hours you worked in Covered Employment, credited Disability Hours, and Self-Payment Hours, or a combination of all those hours in the Calendar Year you retire as follows:

- If you have less than 900 hours, your coverage will end at the end of the Calendar Year in which you retire and you will be offered COBRA Continuation Coverage.
- If you have at least 900 hours but less than 1,300 hours, you will be eligible for Plan II.
- If you have 1,300 or more hours, you will be eligible for Plan III.

2. If the 5-year averaging explained below will make you eligible for Plan III if you were in Plan II during the Calendar Year in which you retire, you will be eligible for the Comprehensive Medical Expense Benefit and Prescription Drug Program (no dental (including orthodontia and periodontal benefits) or vision benefits) for Plan III during the Calendar Year following the Calendar Year in which you retire.

- ***For all Calendar Years thereafter, until you are eligible to participate in Medicare due to becoming age 65***, you and your Dependents will be eligible as follows:

5-Year Averaging

1. The Plan for which you will be eligible will be determined by taking an average of the hours you worked in Covered Employment, credited Disability Hours and Self-Payment Hours for the 5 Calendar Years before the Calendar Year in which you retire, as shown below:

- If you have less than 900 hours, your coverage will end at the end of the Calendar Year in which you retire and you will be offered COBRA Continuation Coverage.
- If you have at least 900 hours but less than 1,300 hours, you will be eligible for Plan II.
- If you have 1,300 or more hours, you will be eligible for Plan III.

2. You and your Dependents will be eligible for the Comprehensive Medical Expense Benefit and Prescription Drug Program (no dental (including orthodontia and periodontal benefits) or vision benefits) of the Plan for which you qualify.

3. When you become eligible to participate in Medicare due to becoming age 65, your benefits will terminate. However, your Dependents will continue to be eligible for the Comprehensive Medical Expense Benefit and Prescription Drug Program (no dental (including orthodontia and periodontal benefits) or vision benefits) of the same Plan for which you had qualified until their benefits terminate according to the *Termination of Dependent Eligibility* provisions below.

DISABILITY RETIREMENT

If you are eligible and elect to receive a disability pension under the Roofers' Pension Plan, the Welfare Plan coverage provided for you and any Dependents will be as follows (subject to the subsection *Eligibility for Medicare* rules.)

- ***For the remainder of the Calendar Year in which you commence disability retirement***, you and your Dependents will continue to be eligible for the Plan of Benefits under which you were covered on the date of your disability retirement.

- ***For the Calendar Year following the Calendar Year in which you commence disability retirement:***

  - You and your Dependents will continue to be eligible only for the Comprehensive Medical Expense Benefit and the Prescription Drug Program (no dental (including orthodontia and periodontal benefits) or vision benefits) of the Plan you were in when you became Totally Disabled; or

  - If you accumulated at least 900 hours under the *Continuing Eligibility* requirements during the Calendar Year in which you commence disability retirement, you and your Dependents will be eligible for all of the benefits under the Plan for which your accumulated hours will provide eligibility.

- **For Calendar Years thereafter until you are eligible to participate in Medicare due to becoming age 65**, you and your Dependents will only be eligible for the Comprehensive Medical Expense Benefit and the Prescription Drug Program (no dental (including orthodontia and periodontal benefits) or vision benefits) under the Plan for which you were eligible at the time you commence disability retirement.

ELIGIBILITY FOR MEDICARE

When you become eligible to participate in Medicare due to your disability, the Plan will coordinate your benefits with Medicare. This will continue until the earlier of the last day of the month preceding the month in which you become eligible to participate in Medicare due to reaching age 65 or until you otherwise lose your eligibility under the Plan.

When you become eligible to participate in Medicare due to reaching age 65, your benefits will terminate on the last day of the month preceding the month in which you become eligible to participate in Medicare due to reaching age 65 (see exception in *Continuation of Benefits After Medicare Eligibility*). However, your Dependents will continue to be covered under the Comprehensive Medical Expense Benefit and the Prescription Drug Program (no dental, (including orthodontia and periodontal benefits) or vision benefits) of the Plan for which they are eligible at the time your eligibility terminates until their benefits terminate according to the *Termination of Dependent Eligibility* provisions below.

BENEFITS FOR SURVIVING DEPENDENTS OF ELIGIBLE RETIREES

If you die while you and your Dependents are eligible for the benefits provided for Eligible Retirees and their Dependents, your surviving Dependents will be entitled to benefits as follows:

- **For the remainder of the Calendar Year in which your death occurs**, your Dependents will continue to be eligible for the same benefits for which they were eligible at the time of your death.

- **For the Calendar Year following the Calendar Year in which your death occurs**, your Dependents will be eligible for the Comprehensive Medical Expense Benefit and the Prescription Drug Program (no dental, (including orthodontia and periodontal benefits) or vision benefits) under the same Plan for which they were eligible at the time of your death without any Dependent Self-Payment to the Fund.

- **For all Calendar Years thereafter**, your surviving Dependents can make Dependent Self-Payments to continue eligibility only for the Comprehensive Medical Expense Benefit and the Prescription Drug Program (no dental, (including orthodontia and periodontal benefits) or vision benefits) of Plan II.

If your Spouse remarries or becomes eligible to participate in Medicare due to becoming age 65 while making Dependent Self-Payments, he or she may still make Dependent Self-Payments to continue coverage for any Children until their eligibility terminates according to the Termination of Dependent Eligibility provisions below. Benefits for surviving Spouses end on the date they remarry or become eligible to participate in Medicare due to becoming age 65.

The same rules that apply to surviving Dependents of active Pension-Vested Employees also apply to surviving Dependents of Eligible Retirees, including the rules regarding Dependent Self-Payment.

COBRA CONTINUATION COVERAGE FOR DEPENDENTS OF ELIGIBLE RETIREES

If your death occurs after your retiree benefits coverage starts, your Dependents may be entitled to elect COBRA Continuation Coverage instead of taking the coverage explained under *Benefits for Surviving Dependents of Eligible Retirees* above.

The election of COBRA Continuation Coverage by any of your Dependents constitutes a permanent rejection of all other coverage under the Plan, and your Dependents may not at any time in the future make Dependent Self-Payments for additional coverage. Your Dependents should carefully compare the benefit coverage, length of the coverage, and the cost of the coverage before making a choice.

If your Dependents elect COBRA Continuation Coverage, they may be entitled to up to 36 months of continued coverage for the health benefits for which they were eligible on the day before your death. This 36-month period begins on the day following the date of your death.

If your death occurs during the Calendar Year in which you retire, and your Dependents elect COBRA Continuation Coverage:

- For the rest of the Calendar Year in which your death occurs, starting on the first day of the month following the month in which your death occurs, no COBRA Payments will be required.

- Starting with the first month of the Calendar Year following the Calendar Year in which your death occurs, COBRA Payments will be required for the remaining months of the 36-month maximum period of COBRA Continuation Coverage.

If your death occurs during the Calendar Year following the Calendar Year in which you retire, and your Dependents elect COBRA Continuation Coverage, COBRA Payments will be required for the entire period of the 36-month maximum COBRA Continuation Coverage period, starting on the first day of the month following the month in which your death occurs. COBRA Continuation Coverage for your surviving Dependents is governed by the COBRA Continuation Coverage Payment Provisions.

CONTINUATION OF BENEFITS AFTER MEDICARE ELIGIBILITY

If you or any of your Dependents become eligible to participate in Medicare due to reaching age 65, all Plan benefits for those Medicare eligible individuals will terminate and the Plan will not coordinate benefits with Medicare. However, an exception to this rule is explained below.

Exception: Those Medicare eligible individuals may be entitled to dental (including orthodontia and periodontal benefits) and vision benefits for a period of time after they become eligible, but only under the following circumstances:

- If those Medicare eligible individuals t become so eligible during the Calendar Year in which you retire or in the Calendar Year following the Calendar Year in which you retire; and

- If those Medicare eligible individuals are eligible for dental (including orthodontia and periodontal benefits) and vision benefits under Plan II or Plan III because you are entitled to the full Plan II or Plan III benefits for the rest of the Calendar Year in which you retire or in the Calendar Year following the Calendar Year in which you retire; then

- Comprehensive Medical Expense Benefits and Prescription Drug Benefits for those Medicare eligible individuals will terminate on the last day of the month preceding the month in which they become so eligible. However, they will be entitled to the dental (including orthodontia and periodontal benefits) and vision benefits , as long as you are otherwise eligible for them if you or your Dependent had not become eligible to participate in Medicare due to reaching age 65.

TERMINATION OF ELIGIBILITY FOR RETIREE BENEFITS

TERMINATION OF RETIREE ELIGIBILITY

Your eligibility for benefits will terminate at 11:59 p.m. on the first to occur of the following dates:

1. The date of your death.

2. The last day of the month preceding the month in which you are eligible to participate in Medicare due to reaching age 65.

3. The date you fail to meet any of the requirements for eligibility for Retiree benefits.

4. The last day of the last month for which the required payment of your Social Security Supplement from your pension benefits from the Roofers' Pension Fund to the Roofers' Unions Welfare Trust Fund was authorized.

5. The date the Trustees terminate the Plan or the Plan of Benefits under which you are covered.

6. The date the Trustees terminate benefits for Retirees.

TERMINATION OF DEPENDENT ELIGIBILITY

Eligibility for your Dependents will terminate at 11:59 p.m. on the first to occur of the following dates:

1. The date the Trustees:

    a. Terminate benefits for Dependents under the Plan or Plan of benefits under which the Dependent is covered; or

    b. Terminate benefits for Dependents of Retirees.

2. The date the Dependent becomes an Eligible Employee under the Plan.

3. The date your eligibility for benefits terminates for reasons other than your death or your eligibility to participate in Medicare.

4. The last day of the month preceding the month that the Dependent is eligible to participate in Medicare due to reaching age 65.

5. The last day of the last month for which the required payment of your Social Security Supplement from your pension benefits from the Roofers' Pension Fund to the Roofers' Unions Welfare Trust Fund was authorized.

6. For a Child, the date the Child fails to meet this Plan's definition of a Dependent, unless the Child is entitled to COBRA Continuation Coverage.

7. For your Spouse, the date of your divorce unless he or she is entitled to COBRA Continuation Coverage.

8. If you die while any of your Dependents are eligible for the benefits provided for Eligible Retirees and their Dependents, eligibility for your Dependents will terminate at 11:59 p.m. on the first to occur of the following dates:

    a. Any applicable date stated in the preceding section.

    b. If COBRA Continuation Coverage is not elected by or on behalf of the Dependent:

        i. At the end of the Calendar Year following the Calendar Year in which you die, unless your Spouse makes an on-time and correct Dependent Self-Payment for continued coverage for himself or herself and/or any Children.

        ii. If your Spouse is continuing coverage for himself or herself and any Children by making Dependent Self-Payments:

            1. The end of the period for which he or she has already made an on-time and correct Dependent Self-Payment for coverage if he or she fails to make a payment on or before the date it is due; or

            2. For your Spouse, the earlier of the date he or she remarries or becomes eligible to participate in Medicare due to reaching age 65. Coverage for any Children will continue if Dependent Self-Payments continue to be

made for them until their eligibility otherwise terminates according to the above provision.

c. If COBRA Continuation Coverage is elected by or on behalf of the Dependent when your death occurs during the Calendar Year in which you retire, at the end of the Calendar Year during which your death occurs, unless an on-time and correct COBRA Payment is made by or on behalf of the Dependent. However, if a correct and on-time Dependent Self-Payment fails to be made, then coverage will terminate at the end of the last period for which a correct and on-time Dependent Self-Payment was made.

d. If COBRA Continuation Coverage is elected by or on behalf of the Dependent when your death occurs during the Calendar Year following the Calendar Year in which you retire but within 18 months of the date your Retiree benefit coverage started, at the end of the month during which your death occurs unless an on-time COBRA Payment is made by or on behalf of the Dependent.

9. If COBRA Payments are being made by or on behalf of the Dependent, at the end of the last day of the last month of the maximum coverage period to which the Dependent was entitled and for which any required COBRA Payments were made by the due date or on the date of occurrence of any of the events stated in *Termination of COBRA Continuation Coverage*, whichever occurs first.

WHEN YOU ARE AGE 65

REIMBURSEMENT OF MEDICARE PART B PAYMENTS (PREMIUMS)

After you (an Eligible Retiree) become eligible to participate in Medicare due to becoming age 65, the Plan will reimburse you for the payments you make for Medicare Part B coverage. If your Spouse is enrolled in Medicare Part B due to reaching age 65, the Plan will also make reimbursements for your Spouse's Medicare Part B payments.

REIMBURSEMENT OF MEDICARE PART D PAYMENTS (PREMIUMS)

After you (an Eligible Retiree) become eligible to participate in Medicare due to becoming age 65, the Plan will reimburse you for a portion of the payments you make for Medicare Part D prescription drug coverage. If your Spouse is enrolled in Medicare Part D due to reaching age 65, the Plan will also make reimbursement for a portion of your Spouse's Medicare Part D prescription drug coverage payments.

PLAN PAYMENTS FOR MEDICARE SUPPLEMENT POLICES

After you (an Eligible Retiree) become eligible to participate in Medicare due to becoming age 65, the Plan will pay you a monthly amount, paid quarterly, to aid you in obtaining a Medicare supplement policy. If your Spouse is age 65 or older and eligible to participate in Medicare, the Fund will pay a monthly amount, paid quarterly, to aid you in obtaining a Medicare supplement policy for your Spouse.

The Plan's payments toward Medicare supplement policies, if any, will be determined by the Trustees and will be indexed annually so that the Plan's payment from year to year is the same percentage of the total premium. However, these payments may be increased, decreased or eliminated at any time and from time to time in the sole and unrestricted discretion of the Trustees.

LIFE EVENTS

At some point in your life, you will probably experience a life event that affects your welfare benefits. It is important that you understand what you or your Dependents need to do when you experience a change in family status.

Notify the Fund Office of any change in your family status.

NOTIFY THE FUND OFFICE

You can help avoid delays in payment of benefits by notifying the Fund Office:

- of new Dependents; or
- when a Dependent is no longer eligible for coverage (you may want to continue his or her coverage through COBRA).

You should also contact the Fund Office to update your:

- beneficiary information, if you experience a change in family status; or
- address, if you move.

When you experience a change in family status, you should contact the Fund Office as soon as possible to provide any required information. It is important that you provide any requested information to the Fund Office because it helps ensure that the Fund Office has your correct address and family information on file. It also enables the Fund Office to keep updated marital status, Dependent information, and information about whether you or your Dependents have other benefits coverage. This information helps in processing your claims quickly and accurately.

ADDING A DEPENDENT

You will need to contact the Fund Office to enroll your Dependents. Adding a Dependent could result from any of the following:

- Having a baby;
- Adopting a Child or having a Child placed with you for adoption; and
- Getting married.

IF YOUR DEPENDENT LOSES ELIGIBILITY FOR COVERAGE

If your Dependent loses eligibility for coverage because of a loss of Dependent status under the Plan, and wants to continue coverage under COBRA, you must contact the Fund Office within 60 days from the date your Dependent loses eligibility.

IN THE EVENT OF DIVORCE

In the event of a divorce, if your ex-Spouse was covered under the Plan and wants to continue coverage under COBRA, you or your ex-Spouse must contact the Fund Office within 60 days from the date of the divorce to request COBRA information from the Fund Office

Also, a divorce invalidates any prior beneficiary designation of your former Spouse for your Loss of Life and Accidental Death and Dismemberment Benefits. You should update your beneficiary designation as soon as possible if you divorce.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

This Plan recognizes Qualified Medical Child Support Orders (QMCSOs) and provides benefits for a Child as determined by a court order in the event of a divorce or other family law action. Orders must be submitted to the Fund Office to determine if the order is a QMCSO, as required under federal law. The Fund Office will provide you with a copy of the Plan's QMCSO procedures, free of charge, upon request.

IF YOU TAKE LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to the:

- Birth, adoption, or placement with you for adoption of a Child;
- Care of a seriously ill Spouse, parent, or child;
- Your serious Illness; or
- A qualifying exigency, or urgent need for leave because your Spouse, son, daughter, or parent is on active duty in the U.S. armed services in support of a military operation in accordance with the final regulations issued by the Department of Labor.

In addition, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member in the U.S. armed services. The service member must be:

- Your Spouse, son, daughter, parent, or next of kin;
- Undergoing medical treatment, recuperation, or therapy for a serious illness or injury incurred in the line of duty while in military service; and
- An outpatient or on the temporary disability retired list of the armed services.

Your eligibility for FMLA leave and benefits will be determined by your Contributing Employer. You are eligible for a leave under FMLA if you:

- Have worked for a Contributing Employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where at least 50 Employees are employed by the Contributing Employer within a 75-mile radius.

The Fund will maintain your prior eligibility status until the end of the leave, provided your Contributing Employer properly grants the leave under federal law and the Employer makes the required notification and payment to the Fund.

If you and your Employer have a dispute over your eligibility and coverage under FMLA, your benefits will be suspended pending resolution of the dispute, in the absence of the required contribution. The Trustees will have no direct role in resolving the dispute. Coverage under the Plan will continue during FMLA leave on the same basis as other similarly situated Employees.

Call your Employer to determine if you are eligible for FMLA leave. During your leave, you will maintain all the coverage offered through the Plan, provided your Employer makes the required contribution to the Fund.

IF YOU ENTER ACTIVE MILITARY SERVICE

If you are on active duty in the military for 31 days or less, you will continue to receive health care coverage from the Plan for up to 31 days, according to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are on active duty in the military for more than 31 days, your coverage under the Plan will normally end. However, USERRA permits you to continue medical, prescription drug, dental, and vision coverage for you and your Dependents at your own expense until the earlier of 24 consecutive months after Plan coverage ends or the end of the period during which you are eligible to apply for re-employment in accordance with USERRA.

You must elect continuation coverage under USERRA for yourself and any of your Dependents who are covered by the Plan on the date coverage ends due to your active duty in the military. Your election for USERRA continuation coverage must be made within 60 days after the date eligibility for medical, prescription drug, dental, and vision coverage terminates due to your active service in the U.S. military. If you do not elect USERRA continuation coverage within the 60-day timeframe, you (and your Dependents) will no longer be eligible for such continuation coverage.

If your medical, prescription drug, dental, and vision benefits are continued under any other continuation of coverage provision of the Plan, (such as COBRA Continuation Coverage or Regular Self-Pay) the periods of USERRA continuation coverage and the other contribution coverage will run concurrently. If another contribution provision provides a shorter contribution period for which the premium is paid in whole or in part by an Employer, then the premium you are required to pay may increase for the remainder of the continuation of coverage period.

Coverage under the Plan will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

Your USERRA continuation coverage may be terminated if:

- You do not pay any required Self-Payment;
- You exhaust the 24-month coverage period;
- The Plan ceases to provide group health coverage;
- You lose your rights under USERRA (for instance, for a dishonorable discharge); or
- You fail to return to work or apply for reemployment within the time required under USERRA.

Following discharge from military service, you may be eligible to apply for reemployment with a Contributing Employer in accordance with USERRA. Such reemployment includes the right to elect immediate reinstatement of your health benefits under the Plan.

IN THE EVENT YOU BECOME DISABLED

If you are an Employee and you become disabled, you and your Dependents may be eligible to continue coverage. See the section *Eligibility During Disability* for how to continue coverage during a period of disability. You may also qualify for Weekly Disability Benefit coverage. If you are a Retiree, you may be eligible for coverage if you are receiving a disability pension under the Roofers' Pension Plan.

IN THE EVENT OF YOUR DEATH

In the event of your death, your surviving Dependents should contact the Fund Office for information on how to apply for the Loss of Life Benefit (and Accidental Death and Dismemberment Benefit, if applicable), and if they would like to continue coverage through Surviving Dependent coverage, or by electing COBRA Continuation Coverage.

COBRA CONTINUATION COVERAGE

You and your Dependents who are "qualified beneficiaries" (see *Note* below) have the right to be offered an opportunity to make COBRA payments for continued health care coverage called "Continuation Coverage," "COBRA Continuation Coverage" or "COBRA Coverage," if coverage is lost due to certain reasons ("qualifying events.")

~Note~

A qualified beneficiary is any person in your family (Employee or Dependent) who was covered under the Plan on the day before the occurrence of a qualifying event and who is entitled to elect COBRA if coverage would be lost because of certain qualifying events. A Child who is born to or placed for adoption with you during a COBRA Coverage period is also a qualified beneficiary.

~ A qualifying event is any of the events stated in the next section that would cause a qualified beneficiary to lose coverage under the Plan.

QUALIFYING EVENTS/MAXIMUM COVERAGE PERIODS

1. **18-MONTH MAXIMUM COVERAGE PERIOD** – You and/or your Dependents are entitled to elect COBRA Coverage and to make COBRA payments for the coverage for a maximum period of up to 18 months after coverage would otherwise terminate due to one of the following qualifying events:

   ~ A reduction in your hours of Covered Employment; or

   ~ Termination of your work in Covered Employment. Under COBRA, retirement is considered termination of employment.

   a. **11-Month Extension Rule** – If you or a Dependent are disabled (as defined by the Social Security Administration for the purpose of disability benefits) as of the date of your termination of employment or reduction in hours, or if you or a Dependent become so disabled at any time during the first 60 days of an 18-month coverage period, the 18-month period may be extended for up to an additional 11 months for up to a total coverage period of 29 months.

   The extension will apply to the disabled person and to all other Covered Persons in your family who are qualified beneficiaries due to your reduction in hours or termination of employment. The amount of the monthly COBRA payments during the extra 11 months of coverage for the family is subject to increase.

   You or the disabled Dependent must notify the Fund Office within 60 days of the disability determination by Social Security and before the end of the initial 18-month period and also within 30 days of the date Social Security determines that you or the Dependent are no longer disabled.

   (This 11-month extension rule does not apply to Dependents during a 36-month maximum coverage period explained in No. 2 below)

   b. **COBRA Coverage During Military Service** – If you or a Dependent are in the Military Reserve and are called up to active duty for at least 30 days, the call-up is considered a qualifying event under COBRA. You or the Dependent are entitled to elect COBRA Coverage for a period of up

to 24 months and to make COBRA payments for the coverage, regardless of any coverage provided by the government for your military service. The Plan will pay primary benefits before the military/government pays, except for service-related disabilities.

2. **36-MONTH MAXIMUM COVERAGE PERIOD** – Your Dependents are entitled to elect COBRA Coverage and to make COBRA payments for the coverage for up to 36 months after coverage would otherwise terminate due to one of the following qualifying events:

   a. Your divorce or legal separation from your Spouse; or

   b. Your entitlement to Medicare; or

   c. A Child's failure to meet the definition of a Dependent; or

   d. Your death.

3. **MULTIPLE QUALIFYING EVENTS** – If your Dependents are covered under an 18-month COBRA period due to termination of your employment or a reduction in your hours and then a second qualifying event of your death, your divorce or legal separation, your entitlement to Medicare or a Child losing Dependent status occurs:

   a. The affected Dependent is entitled to extended COBRA Coverage for up to a maximum of 36 months minus the number of months of COBRA Coverage already received under the 18-month period.

   b. Only a person who was your Dependent on the day before the occurrence of the first qualifying event (your employment termination or hours reduction) is entitled to elect this extended coverage when a second qualifying event occurs, except that a Child who is born to you or placed with you for adoption during the first 18-month continuation period will also have the election rights.

NOTIFICATION RESPONSIBILITIES

You and your Dependents are responsible for notifying the Plan in writing and supplying the appropriate documentation within the later of 60 days of the date of your divorce or legal separation or a Child losing Dependent status or within 60 days of the date coverage for the affected person(s) would terminate due to such an event. If such notification is not given within 60 days of the event, the affected Dependent will not be entitled to elect COBRA Coverage.

BENEFITS UNDER COBRA COVERAGE

A person electing COBRA Coverage may elect the same Plan of benefits for which he was eligible on the day before the qualifying event, either the Comprehensive Benefit and Prescription Drug Program, but not dental, orthodontia, periodontal or vision benefits, or the Comprehensive Benefit and the Prescription Drug Program plus the dental, orthodontia, periodontal, and vision benefits. Death, AD&D and Weekly Disability Benefits are not provided to you under COBRA Coverage.

ELECTION NOTICES AND FORMS

When the Plan is notified of a reduction of your hours or termination of your employment, the Fund Office will send you information about electing and paying for COBRA Coverage. This information will

also be sent to your Dependents when timely notification of a qualifying event (such as when a Child reaches the limiting age) is received. The letters and forms explain when coverage will terminate, COBRA Coverage election rights, the payment due dates, the amount of the monthly COBRA payments, and when the election form must be returned.

ELECTING COBRA COVERAGE

Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate election of COBRA Coverage. If you elect COBRA Coverage for yourself and your Dependents, your election is binding on your Dependents. If you don't elect COBRA Coverage for your Dependents when they are entitled to COBRA Coverage, your Spouse has the right to elect COBRA Coverage for up to 18 months for herself/himself and any Children within the time you could have elected the coverage.

The person electing COBRA Coverage has 60 days after he is sent the Election Notice or 60 days after his coverage would terminate, whichever is later, to return the completed Election Form. An election of COBRA Coverage is considered to be made on the date the Election Form is personally delivered or mailed back to the Fund Office (the postmark date will govern the date of mailing – see No. 3 in the following section). If the Election Form is not returned to the Fund Office within the allowable period, you and/or your Dependents will have waived your right to COBRA Coverage.

COBRA PAYMENT RULES

1. The amount of the monthly COBRA payment is determined by the Trustees based on federal regulations. The initial monthly payment amount due will be shown on your Election Notice, and is subject to change, from time to time.

2. The initial payment must be made within 45 days after the date of election, and will be for coverage provided between your termination date and the date the initial payment is made.

3. Subsequent COBRA payments must be made monthly, as of the first day of each succeeding month (the "due date") or within 30 days of the due date. Your COBRA payment will be considered on time if it is delivered or mailed by the due date or within 30 days of the due date. (Postmarks affixed by the U.S. Postal Service will be considered proof of date of mailing. Postage meter imprints or any other evidence of mailing date, including date imprints by overnight courier services such as UPS, will not be considered proof of date of mailing unless payment is actually delivered to the Fund Office no later than the first business day immediately following the mailing date shown.)

4. If a COBRA payment is not made within the time specified, COBRA Coverage for all affected covered Dependents will terminate.

TERMINATION OF COBRA COVERAGE

COBRA Coverage for a person will terminate before the end of the applicable maximum coverage period when the first of the following events occurs:

1. A correct and on-time COBRA payment is not made to the Fund with respect to coverage for the person; or

2. After electing COBRA Coverage, the person becomes entitled to Medicare benefits; or

3. The Plan no longer provides health coverage to any person; or

4. The person has been receiving extended COBRA Coverage for up to an additional 11 months due to his or another family member's disability, and the Social Security Administration has determined that he or the other family member is no longer disabled; or

5. After electing COBRA Coverage, the person becomes covered under another group health plan as an Employee or otherwise.

6. COBRA Continuation Coverage may be terminated if the Trustees find a material misstatement which resulted in COBRA coverage having been erroneously granted.

CERTIFICATION OF CREDITABLE COVERAGE

When your coverage ends or when your Dependent's coverage ends and again when COBRA Continuation Coverage ends, you (or your Dependent) will be provided with certification of the length of coverage under the Plan. The Fund Office will automatically provide this certification when coverage ends and when COBRA Continuation Coverage ends for you or your Dependent.

BENEFIT DESCRIPTIONS

LOSS OF LIFE BENEFIT

LOSS OF LIFE BENEFITS

If you die while you are eligible for Loss of Life Benefits, the amount shown in the Schedule of Benefits for the Plan of benefits for which you are eligible at the time of your death will be paid to your beneficiary regardless of the cause of death. A certified copy of your death certificate or some other evidence acceptable to the Trustees must be provided to the Fund Office within 12 months of your death. Your beneficiary or beneficiaries may provide written notice of your death after more than 12 months if it was not reasonably possible to provide proof within 12 months of your death.

BENEFICIARY DESIGNATION

You may name the person you want to receive your Loss of Life Benefit as your beneficiary. Be sure that an up-to-date beneficiary designation form is on file in the Fund Office. You can change your named beneficiary at any time by completing a new form and returning it to the Fund Office. **The beneficiary designation form must be received by the Fund Office during your lifetime and will take effect on the date your written designation form is received by the Fund Office during your lifetime**. If the person you named as your beneficiary dies before you, you should submit a new beneficiary designation form.

IMPORTANT: Your beneficiary designation form is void if any of the following events occur:

- You get married, if you weren't married when your previous beneficiary designation form was filed with the Fund Office and your new Spouse is not your named beneficiary; or

- You become divorced from your Spouse, if your former Spouse was your named beneficiary and you do not rename her/him as your named beneficiary on your new beneficiary designation form filed with the Fund Office.

If you do not submit a new beneficiary designation form to the Fund Office after either of these events occur (which may rename those previously designated individuals if you so desire), upon your death your Loss of Life Benefit will be paid in the order stated in the following paragraph.

If you do not have a valid designated beneficiary form on file with the Fund Office, or if your beneficiary dies before you do, or if you have not changed your beneficiary designation form as explained above, your beneficiary will be the first of the following successive classes in which there is one or more survivors: your Spouse, your Children, your parents or your estate. In such case, if there is more than one survivor in the class, the survivors in that class will share the benefit equally.

Any amount payable to a beneficiary who is a minor Child, or who is otherwise incapable of giving a valid release for any payment due, may be paid to the legally appointed guardian or in the absence of such appointment, to such person or institution in the opinion of the Trustees has assumed the care or custody of the beneficiary, for the sole use and benefit of such beneficiary.

CONTINUATION OF LOSS OF LIFE BENEFIT DURING PERMANENT AND TOTAL DISABILITY

If you become Permanently and Totally Disabled due to an accidental occupational or non-occupational injury or sickness while covered under the Plan, Loss of Life Benefits will be continued at no cost if:

1. your Total Disability began before your 60th birthday;

2. you are Totally Disabled and completely unable to perform any work or to engage in any occupation or employment for compensation, remuneration, wage, or profit;

3. you submit medical evidence acceptable to the Trustees that your disability will be permanent;

4. notice and proof of Total Disability is furnished to the Trustees within 12 months following the date you became disabled;

5. you provide proof of continuance of your Total Disability when requested by the Trustees; and

6. you submit to a medical examination by Physicians designated by the Trustees when and so often as the Trustees reasonably require, but not more than once a year after you have been covered under this continuation provision for 24 consecutive months.

Your eligibility for continuation of the Loss of Life Benefit will terminate on the first to occur of the following:

1. the date on which you are no longer Permanently and Totally Disabled;

2. the date on which you fail to furnish proof of continuance of Total Disability; or

3. the date on which you fail to submit to a medical examination, when requested by the Trustees.

If you die during the first 12 months of Permanent and Total Disability, your Loss of Life Benefit will be paid to your beneficiary as stated above even if you had not yet furnished the proof of disability before your death.

Loss of Life Benefit for Retirees

A Retiree will be eligible for the Loss of Life Benefit only if he or she meets all of the following requirements:

- he or she is an Eligible Retiree (except for age); and

- he or she is retired under the *Disability Retirement* provisions; and

- he or she became eligible for continued Loss of Life Benefits under the above *Continuation of Loss of Life Benefit During Permanent and Total Disability* provisions before his or her retirement and continues to be eligible under those provisions.

When a Retiree who meets the above requirements dies, his or her Loss of Life Benefit will be paid to his or her beneficiary(ies) according to the provisions governing payments to beneficiaries of Eligible Employees.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT

PAYMENT OF BENEFITS

Payment will be made to you or your beneficiary as specified below under this benefit if death, dismemberment or loss of sight occurs within 90 days of a non-occupational accidental injury and results solely from that injury. The beneficiary designation rules for this Accidental Death and Dismemberment Benefit are the same as those for the Loss of Life Benefit.

The full amount of your Accidental Death and Dismemberment Benefit is shown in the Schedule of Benefits under the Plan of benefits under which you are eligible. The amount payable for all losses resulting from any one accident will not be more than the full amount. If you die as a result of an injury, your beneficiary will receive the full benefit amount. A certified copy of your death certificate or other evidence of your loss acceptable to the Trustees must be provided to the Fund Office within 12 months of your death or loss. Your beneficiary may provide written notice of your death after more than 12 months if it was not reasonably possible to provide proof within 12 months of your death.

If you suffer dismemberment or loss of sight as a result of an injury, payments will be made as shown on the Table of Losses below. If you suffer any combination of these losses as the result of one accident, only one amount (the largest) is payable for all losses. For each of the following losses, the Plan will pay:

Types of Losses	
Loss of Life	Full amount – Paid to your beneficiary
Two hands, two feet, or sight of two eyes	Full amount – Paid to you
One foot and sight of one eye, or one hand and sight of one eye, or one hand and one foot	Full amount – Paid to you
One hand, one foot, or sight of one eye	One-half the full amount – Paid to you

Loss of hands and feet means dismemberment by complete and irrevocable severance through, or above, the wrist or ankle joints; loss of sight means the entire and irrecoverable loss of sight including light perception.

EXCLUSIONS AND LIMITATIONS

No payment will be made under the Accidental Death and Dismemberment Benefit for:

1. any loss that occurs more than 90 days after the date of the accident causing the loss; or

2. any loss resulting from travel or flight as a pilot or crew member in any kind of aircraft, or as a passenger on a private or unscheduled airplane flight; or

3. any loss resulting from any accidental injury, sickness or disease sustained while performing any act or duty pertaining to any occupation, employment or activity, including self-employment,

whether or not benefits would have been or are payable in whole or part under any Workers' Compensation Law, Employers' Liability Law, Occupational Diseases Law or similar law.

The following are not considered "accidents" and no payments will be made under the Accidental Death and Dismemberment Benefit for:

1. intentionally self-inflicted injury, suicide or attempted suicide, while sane or insane or whether or not due to a mental impairment of any kind; or

2. bodily or mental infirmity, ptomaines, or viral or bacteria infections other than a pyogenic infection occurring through and at the time of an accidental cut or wound; or

3. disease, or any type of medical or surgical treatment; or

4. any injury or sickness which, in the sole judgment of the Trustees, based on available evidence, was sustained in the course of, or which was contributed to by, the Eligible Employee's commission or attempted commission of a felony, whether or not such person is convicted of a crime; or

5. war or any act of war, whether declared or undeclared, or riot, insurrection, mob violence, or terrorist attack.

WEEKLY DISABILITY BENEFIT

WEEKLY DISABILITY BENEFITS

Weekly Disability Benefits are payable if you are an Eligible Employee and you become Totally Disabled. For the purpose of this benefit, you are "Totally Disabled" if you are totally prevented from performing any and every duty of your normal occupation or employment as a result of a non-occupational accidental bodily injury or sickness and you are not performing or engaging in any occupation, employment or activity, including self-employment, for wage, remuneration or profit.

PAYMENT OF BENEFITS/WHEN BENEFITS START

You will be paid the amount shown in the Schedule of Benefits for the Plan of benefits under which you are eligible for each week you are Totally Disabled, up to the maximum number of weeks payable for any one period of Total Disability.

A Total Disability will be considered to have started on the first date that you are actually examined or treated by a Doctor and there is medical evidence acceptable to the Trustees that you were Totally Disabled as of such date. Benefits will start on the 1st day of Total Disability due to an accidental injury if the Total Disability starts within 10 days of the accident that caused the injury. If the Total Disability starts more than 10 days after the accident that caused the injury, benefits will start as though the Total Disability is due to sickness. Benefits will start on the 8th day of Total Disability due to sickness. A total disability due to maternity, pregnancy or pregnancy-related conditions is treated as though caused by sickness.

Weekly disability payments will be reported on a W-2 Form. Consult with a tax advisor or counsel regarding any tax liability that may arise from these payments. In addition, the Plan will withhold 20% for federal taxes and your share of FICA (Social Security taxes) from each weekly payment made to you.

If you are undergoing covered inpatient Treatment for Chemical Dependency in a Hospital or an approved treatment facility or partial inpatient Treatment for Chemical Dependency, Weekly Disability Benefits will be payable during the Treatment Period if Comprehensive Medical Expense Benefits are payable for the treatment. No Weekly Disability Benefits will be payable beyond the first to occur of: (1) the date the inpatient Treatment is completed, or (2) the date that you have received the maximum Weekly Disability Benefits payable per period of Total Disability.

PERIODS OF DISABILITY

One Period of Total Disability: If you have two or more periods of Total Disability due to the same cause, and they are separated by less than one week of full-time work in Covered Employment, they will be considered one period of Total Disability.

Two or More Periods of Total Disability: If you have two or more periods of Total Disability, you will be considered to have more than one period of Total Disability if:

- You have two or more periods of Total Disability due to totally unrelated causes; and
- You return to full-time work in Covered Employment for one 8-hour day in between the periods of Total Disability.

EXCLUSIONS AND LIMITATIONS

No payment will be made under the Weekly Disability Benefit:

1. for any disability resulting from an injury or sickness that occurs while you are not covered under the Plan or while you are making COBRA payments;

2. for any disability that does not meet the definition of Total Disability;

3. for any disability for which you are not under the direct and continuing care of a Doctor;

4. due to Chemical Dependency other than as stated above;

5. for any disability that results from an accidental bodily injury, sickness, or disease sustained while you were performing any act of employment, including self-employment, or doing anything pertaining to any occupation or employment for remuneration or profit;

6. for any disability that results from an injury or sickness incurred while committing a felony or engaging in an illegal occupation; or

7. for any disability that results from an injury, sickness, or disease sustained while performing any act or duty pertaining to any occupation or employment or for which benefits would have been, may be, or are payable in whole or in part under any Workers' Compensation Law, Occupational Diseases Law, or similar law.

COMPREHENSIVE MEDICAL EXPENSE BENEFIT (COMPREHENSIVE BENEFIT)

All of the Covered Medical Expenses that you and your Dependents incur for treatment of injuries or sicknesses are considered for payment under the Comprehensive Medical Expense Benefit (called the Comprehensive Benefit). Benefits are paid according to the benefits, limitations and allowances stated in the Schedules of Benefits, based on the Plan of benefits under which you are covered and whether or not PPO Hospitals and Doctors are used.

HOW THE COMPREHENSIVE BENEFIT WORKS

The Plan will pay the copay percentage shown in the Schedules of Benefits if you incur Covered Medical Expenses while covered under the Plan after you have satisfied all applicable deductibles. The Plan will not pay benefits after any applicable maximum benefit limitation has been reached. In addition, special limitations apply to certain types of expenses.

How Benefits Are Paid

Maximum Benefits

The Schedules of Benefits show the maximum benefits each Covered Person is entitled to receive under the Plan. Maximums may apply to the benefits paid by the Plan during a Calendar Year, or during a person's lifetime or during some other stated time period. The amounts paid by the Plan on your behalf for the Covered Prescription Drugs you purchase under the Plan's Prescription Drug Program do not apply to any maximum benefit limitation.

- ***Comprehensive Benefit Calendar Year Maximum*** - Benefits paid under any Plan shall apply towards all maximums, including the Comprehensive Benefit, applicable to all Plans.

- ***Other Maximum Benefits*** - The Schedules of Benefits show other maximum benefits and allowances for certain categories of treatment that apply to each Covered Person during a Calendar Year or during the Covered Person's lifetime. Once a Covered Person has received benefits totaling any applicable dollar amount during a stated period of time or has received benefits up to any applicable allowances, the Covered Person will not be entitled to any further benefits for that type of treatment during the stated period of time

Deductibles

A deductible is an amount deducted from the Covered Medical Expenses incurred before Plan benefits are paid. The amounts of the various deductibles are shown in the Schedules of Benefits.

Calendar Year Deductibles

- ***Individual Deductible*** - The individual deductible applies to you and each Covered Person in your family each Calendar Year (unless your family deductible is satisfied). Covered Medical Expenses incurred by a person during a Calendar Year are added together. After these expenses total the Covered Person's individual deductible during a Calendar Year, he or she has satisfied the deductible and the Plan will pay the applicable copay percentage of the amount in excess of the deductible for any additional Covered Medical Expenses the Covered Person incurs during

the rest of that Calendar Year. Each person only has to satisfy his or her deductible once each Calendar Year. In addition, any amount of Covered Medical Expenses used to satisfy a person's deductible during October, November or December of a Calendar Year will also be applied toward his or her deductible for the next Calendar Year.

- ***Family Deductible*** -Once three Covered Persons in a family have each satisfied their individual deductibles during a Calendar Year, no further individual deductibles will have to be satisfied by members of that family for that Calendar Year.

Calendar Year deductibles do not apply to certain categories of Covered Medical Expenses. These categories are indicated in the Schedules of Benefits.

Additional Deductibles

- **Hospital Review Noncompliance Deductible** - If the appropriate Review Manager is not notified (as specified in the section on *Review Programs*) before a Hospital admission or within 24 hours of an Emergency Admission, an additional deductible is applied to the Covered Medical Expenses incurred during that Hospital stay. Any such deductible will be in addition to any other deductibles that may apply to the Covered Medical Expenses.

- **Surgery Review Noncompliance Deductible** - If the Medical Review Manager is not notified (as specified in the section on *Review Programs*) before any type of non-emergency surgery costing more than $5,000 or if a required second opinion on the surgery is not obtained, an additional deductible is applied to the Covered Medical Expenses incurred for and in connection with each such occurrence of surgery. The deductible applies whether the surgery is performed on an inpatient or outpatient basis. Any such deductible will be in addition to any other deductibles that may apply to the Covered Medical Expenses.

- **Emergency Room Deductible** - Each time that a Covered Person goes to a Hospital emergency room for emergency treatment of an injury or sickness, an additional deductible is applied to the Covered Medical Expenses incurred for that treatment. Any such deductible will be in addition to any other deductibles that may apply to the Covered Medical Expenses and will apply whether a PPO or non-PPO Hospital is used. If a Covered Person is admitted to the Hospital as an inpatient directly from the emergency room as a result of the condition requiring the emergency care, this deductible will not apply.

- **Non-PPO Hospital Deductible** - Each time that a Covered Person is admitted as an inpatient to a non-PPO Hospital for treatment of an injury or sickness, an additional deductible is applied to the Covered Medical Expenses incurred for that hospitalization. Any such deductible will be in addition to any other deductibles that may apply to the Covered Medical Expenses.

- **Non-PPO Doctor Deductible** - Each time a Covered Person incurs Covered Medical Expenses in connection with an office visit with a non-PPO Doctor, an additional deductible is applied to the charges incurred for that office visit. Any such deductible will be in addition to any other deductibles that may apply to the Covered Medical Expenses. This deductible applies to all office visits with a non-PPO Doctor, even to Medical Emergencies.

Rules Governing Deductibles

1. Only charges considered Covered Medical Expenses can be used to satisfy any deductible.

2. Any Covered Medical Expenses used to satisfy a particular deductible cannot be used toward satisfaction of any other deductible.

3. Prescription Drug Program copayments do not apply toward satisfaction of any deductible.

4. Payments made for Covered Medical Expenses used to satisfy any deductible will not apply toward meeting any out-of-pocket limit amount.

Plan Copay Percentages

A Plan copay percentage is the percentage amount payable by the Plan if a Covered Person incurs Covered Medical Expenses during a Calendar Year after all applicable deductibles, or the family deductible, is satisfied, subject to the out-of-pocket limits described below. The Plan copay percentages are shown in the Schedules of Benefits.

Out-of-Pocket Limits

An out-of-pocket limit is the maximum you, as a Covered Person, have to pay out-of-pocket for your or your family's share of the copay percentage for Covered Medical Expenses incurred during a Calendar Year. Covered Medical Expenses accumulated during a Calendar Year toward meeting an out-of-pocket limit do not carry over to the next Calendar Year. The individual and family out-of-pocket limit amounts for each Plan are shown in the Schedules of Benefits.

After an out-of-pocket limit is met during a Calendar Year, the Plan pays 100% as follows:

1. After out-of-pocket expenses totaling your individual out-of-pocket limit have been paid by or on your behalf as your copay percentage share of Covered Medical Expenses incurred during a Calendar Year, the Plan will pay 100% of the Covered Medical Expenses that you incur during the remainder of that Calendar Year, subject to the maximum benefit limitations and additional deductibles.

2. After out-of-pocket expenses totaling your family out-of-pocket limit have been paid on behalf of two or more Covered Persons in your family as their copay percentage share of Covered Medical Expenses incurred during a Calendar Year, the Plan will pay 100% of the Covered Medical Expenses all the members of your family incur during the remainder of that Calendar Year, subject to the maximum benefit limitations and additional deductibles.

3. Out-of-pocket payments made for any of the following **do not count** toward meeting any out-of-pocket limits:

    a. Deductibles (Calendar Year Deductibles, Hospital and Surgical Review Noncompliance Deductibles, Emergency Room Deductibles, Non-PPO Hospital Deductibles or Non-PPO Doctor Deductibles).

    b. Prescription Drug Program copay amounts.

    c. Amounts of Covered Medical Expenses deducted for certain inpatient and partial inpatient treatments of Chemical Dependency and Mental/Nervous Disorders.

    d. Charges not considered Covered Medical Expenses or any portion of a charge that is not Reasonable and Customary.

    e. Charges remaining or incurred after any maximum benefit or allowance has been reached for a particular type of treatment or condition during a stated period of time.

    f. Covered Medical Expenses for obesity surgery or infertility treatment.

ENROLLMENT DATE – "Enrollment date" is the earliest date for which a Contributing Employer is obligated to make a Contribution to the Plan on your behalf by reason of employment. If you have Dependents on your enrollment date, that date is also your Dependents' enrollment date. If a person becomes your Dependent after your enrollment date and you have submitted the proper documentation to the Fund Office, that person's enrollment date is the date the person became your Dependent (see *Enrolling New Dependents* for more information.)

COVERED MEDICAL EXPENSES

Covered Medical Expenses are charges for Covered Expenses actually incurred by a Covered Person for services and supplies that are Medically Necessary and that are required for treatment of the person as a result of a non-occupational bodily injury or sickness. Benefits payable for Covered Medical Expenses are subject to the maximum benefits and allowances shown in the Schedules of Benefits and to all other limitations and exclusions. Only the amount of a charge that is Reasonable and Customary will be considered a Covered Medical Expense.

Covered Medical Expenses will be limited to charges incurred for the following types of services, supplies, and treatments:

1. **Hospital room and board** in semi-private rooms, wards, intensive care and coronary care units, and private rooms if medically required for communicable or contagious diseases. Covered Medical Expenses for private rooms for all other purposes will be the Hospital's most common semi-private room rate. If a Hospital has only private rooms, Covered Medical Expenses will be 95% of the Hospital's most common private room rate. Included are all charges made by a Hospital for room, board, general duty nursing and any other Medically Necessary services and supplies. Nursery room and board and related services for newborns are also covered, if the Child is eligible at birth. Charges for professional services of Doctors, private duty nurses or any type of intensive nursing care are not included in a room and board charge.

2. **Other Medically Necessary** services and supplies furnished by a Hospital to a Covered Person.

3. **Services and supplies provided as a result of non-emergency surgery** in a Hospital outpatient department or in a PPO network Outpatient Surgical Facility, including surgeons' services, anesthesia, radiology, pathology, drugs and any other miscellaneous charges rendered at the PPO network Outpatient Surgical Facility on the date of surgery. Precertification is not required for any surgeries that cost less than $5,000.

4. **Skilled Nursing Facility** room and board and necessary services and supplies are covered if the facility meets the Plan's definition of a Skilled Nursing Facility, and the confinement meets all of the following requirements:

    a. A Doctor certifies that the confinement and nursing care are necessary for the patient's recuperation from an injury or sickness;

    b. The confinement:

        i. is preceded by a Hospital confinement for which Plan benefits are payable; and

        ii. starts within 14 days after termination of the Hospital confinement; and

        iii. is due to the condition that required the previous Hospital confinement; and

c. The attending Doctor personally sees the patient at least once each 30 days and certifies that continuation of the confinement is necessary for continued treatment of the condition requiring the confinement.

5. **Doctor's services,** for surgery as well as medical care and treatment, provided in or out of a Hospital.

6. **Second and third surgical opinions** if recommended by the Medical Review Manager.

7. Only the following **dental care** and treatment provided by a Doctor or Dentist:

   a. Treatment of an injury to the jaw or to sound natural teeth, provided the treatment is received within 12 months of the injury; and

   b. Services and necessary associated charges for surgical removal of partially or wholly bony impacted teeth.

8. **Physical Therapy** by a registered physical therapist (R.P.T.) rendered in or out of a Hospital upon the recommendation of the attending Doctor up to the Calendar Year maximum number of treatments. Treatments which exceed the Calendar Year Maximum may be covered if precertification is obtained from the Medical Review Manager that continuing treatment is Medically Necessary.

9. **Occupational Therapy** by a licensed occupational therapist (O.T.) provided:

   a. the therapy is ordered by a Doctor for the purpose of compensating for functional loss caused by a non-occupational injury, sickness or congenital defect; and

   b. the therapy is provided in accordance with a written treatment plan approved by the prescribing Doctor; and

   c. treatments which exceed the Calendar Year Maximum may be covered if precertification is obtained from the Medical Review Manager that continuing treatment is Medically Necessary.

10. **Speech therapy** by a registered speech therapist (S.T.), but only if the therapy is required as a result of massive brain insult, congenital defect of the mouth and/or palate, or surgery on the mouth, palate, larynx, and/or vocal cords.

11. **Treatment of Chemical Dependency,** subject to the provisions stated in *Benefits for Treatment of Chemical Dependency.*

12. **Treatment of Mental or Nervous Disorders,** subject to the provisions stated in *Benefits for Treatment of Mental or Nervous Disorders.*

13. **Transportation** services as follows:

   a. Medically Necessary emergency professional ambulance service to the nearest Hospital located within the U.S.A. that has the medical staff and facilities necessary to provide such treatment from the place where the injury happened or where the initial symptoms began.

   b. If a Covered Person is receiving treatment for a covered injury or a sickness at a medical facility, and the covered injury or sickness requires urgent Medically Necessary treatment

that is not available at that facility, the initial transportation to a Hospital equipped to provide such treatment will be covered if the transportation is:

i. by ground ambulance, or if there are sound medical reasons the patient cannot be transferred by ground ambulance and it is Medically Necessary he be transferred by air ambulance; and is

ii. to the nearest Hospital located within the U.S.A. that has the medical staff and facilities necessary to provide such treatment.

c. Other Medically Necessary professional ambulance transportation to or from a Hospital within the same metropolitan area within the U.S.A., provided that:

i. Medically Necessary treatment of the patient's covered injury or sickness is not available at the Hospital at which the patient is receiving treatment; and

ii. the patient's medical condition requires medical services during the transfer (such as the monitoring of vital signs, the administration of drugs, medications or fluids) and such medical services cannot be provided by a means of conveyance other than a professional ambulance.

14 **Treatment of infertility,** including diagnostic testing, surgical or medical treatment and prescription drugs to promote conception by natural or artificial means of any kind. The Covered Medical Expenses incurred for infertility treatment will not apply towards the individual's or family's out-of-pocket limits. Benefit paid under any Plan shall apply towards all maximums, including the Comprehensive Benefit, applicable to all Plans.

15. **Services and supplies rendered as a result of pregnancy**, including abortion procedures, provided only for Eligible Employees and Eligible Retirees and Spouses of such Employees and Retirees.

An Eligible Employee or Spouse and her newborn infant will receive at least 48 hours of inpatient Hospital care following a normal vaginal delivery and at least 96 hours of inpatient Hospital care following a Cesarean section. Further, the Plan will not require the provider (Hospital or Doctor) to obtain authorization from the Plan for prescribing a length of stay not in excess of these periods. The attending Doctor may however, after consulting with the mother, discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a Cesarean section. The Plan will provide benefits for the Covered Medical Expenses incurred during the prescribed time period, subject to the applicable Schedules of Benefits and to all applicable Plan benefit provisions, maximums and limitations, except that the Hospital Review Program Noncompliance Deductible will not apply.

16. **Services and supplies rendered in connection with an elective sterilization procedure,** provided only for Eligible Employees, Eligible Retirees, and Spouses of such Employees and Retirees.

17. **The following Medically Necessary services and supplies:**

a. **Drugs and medicines** that:

i. are identified by a prescription number;

ii. are dispensed by a licensed pharmacist;

iii. may only be purchased on the written prescription of a Doctor; and

iv. are purchased through the Plan's Prescription Drug Program or are obtained in connection with an inpatient or outpatient hospitalization.

The following are also covered, but only when they are prescribed by a Doctor, are Medically Necessary to treat and/or to monitor a patient's diabetes and are purchased through the Plan's Prescription Drug Program: insulin, needles, lancets, glucometers and test strips.

Covered Medical Expenses do not include any drugs or medications that are excluded from coverage, or that are used in connection with any type of treatment or condition that is excluded from coverage, even though such drugs or medications are obtained with a Doctor's prescription.

b. The first pair of **cataract lenses** required after each cataract surgery.

c. **Whole blood** or blood plasma (if not replaced) and its administration.

d. **Oxygen** and rental of the equipment for the administration of oxygen.

e. **Rental of a non-motorized wheelchair**, a hospital-type bed, mechanical equipment that is necessary for treatment of respiratory paralysis, and other durable equipment for therapeutic treatment. If the Trustees or their representative determines that in their sole and unrestricted discretion that it is in the Plan's best interest to do so, the Plan may purchase and maintain such equipment. For power wheelchairs (electric or battery powered, including scooters and devices), the Plan will pay up to $10,000 during the lifetime of any eligible participant. For a Child who outgrows a power wheelchair, if at least five years has passed since the purchase of the Child's last covered power wheelchair, the Plan will pay up to an additional $10,000 for a replacement. This maximum also applies to any rental charges incurred prior to the purchase of power wheelchairs and any necessary maintenance.

f. **Casts**, splints, crutches, trusses and braces (other than dental braces).

g. **Radiation therapy**, including x-ray, nuclear medicine and chemotherapy.

h. **X-rays and laboratory tests**, analyses or tests made for diagnostic or treatment purposes, and radiology and pathology studies.

If a Covered Person receives a Medically Necessary MRI, CT scan or PET scan that is performed at a diagnostic imaging network facility, the Plan will pay 100% of the charge – no deductible will apply.

i. **Anesthetics** and their administration, including administration of anesthesia by a Certified Registered Nurse Anesthetist (CRNA).

j. **Surgical supplies**, including supplies required to aid any impaired physical organ or part of an organ in its natural bodily function and appliances to replace physical organs or parts of organs, such as artificial limbs and eyes.

k. **Orthopedic shoes** for treatment of a congenital deformity. The orthopedic shoes must be prescribed, recommended or provided by a health care practitioner.

l. Orthotics

m. Sleep studies and CPAP (continuous position airway pressure) equipment.

18. **Chiropractic treatment** subject to the Calendar Year maximum benefit specified in the Schedules of Benefits. Covered Chiropractic treatment includes, but is not limited to:

a. spinal adjustment and manipulation to skeletal or other body structures;

b. spinal analysis; and

c. x-rays taken in conjunction with (a) and (b).

19. **Nursing care** (limited to a total of 90 Shifts per Calendar Year) as follows:

a. Private duty nursing care provided in the patient's home when the attending Doctor certifies in writing that the nursing care is necessary and is not for the purpose of companionship. The nursing care must be provided by an R.N. or an L.P.N.; and

b. The services and supplies listed below which are provided by or through a Home Health Agency to a Covered Person in his home after a hospitalization, provided the following requirements are met:

i. A program of home nursing care is established and approved in writing by the patient's Doctor within 7 days after termination of an inpatient Hospital stay; and

ii. The Doctor certifies that the home care is for the same or related condition for which the patient was hospitalized and that proper treatment of the patient's condition would require Hospital confinement in the absence of the services and supplies provided as part of the program of home care; and

iii. The home care is provided by or through a Home Health Agency.

c. Only Medically Necessary charges made for the following are considered Covered Medical Expenses:

i. Part-time or intermittent nursing care provided by or under the supervision of a R.N. or L.P.N. and medical services by interns and residents in training under an approved teaching program of a Hospital affiliated with the Home Health Agency; and

ii. Medical social services provided under the direction of a Doctor; and

iii. Part-time or intermittent home health aide services; and

iv. Medical supplies (other than drugs and biologicals) and the use of medical appliances; and

v. Any of the foregoing items and services which are provided on an outpatient basis at a Hospital or Skilled Nursing Facility under arrangements made by the Home Health Agency and which involve the use of equipment of such a nature that cannot be readily made available to the patient in his or her home or that are furnished at such facility to which the patient has gone to receive any item or services involved in the use of such equipment (excluding transportation of the person.)

20. **Medical Care and treatment** provided by a Nurse Practitioner.

21. **Medical Care and treatment** provided by a Physician's Assistant.

22. **Nurse Surgical Assistants.** Charges will be paid at 85% of 20% of the benefits paid to the primary surgeon, which varies depending on whether a PPO network or non-PPO network surgeon is used.

23. **Medical Care and treatment** provided by Convenient Care Clinics.

24. **Hearing aids**, once every 3 calendar years, and related services, supplies and repairs. Battery replacements are not covered. Benefits paid under any Plan shall apply towards all Plans.

25. **Two gynecological examinations per Calendar Year**, including two Pap smears and two bilateral mammograms and a screening test for the Human Papilloma Virus (HPV) every three years for female Covered Persons over age 30.

26. **One routine prostate examination and prostate-specific antigen (PSA) test** per Calendar Year for males over age 40 (and for Retirees under age 65). Any charges in excess of the scheduled maximum benefit shown in the Schedules of Benefits are not payable by the Plan.

27. **Routine physical examinations** as follows:

    a. ***For Covered Persons Over age 18*** - One examination every 36 months, including laboratory tests and x-rays that are appropriate for the patient's age, gender and medical history.

    b. ***For Covered Persons under age 19*** - Examinations each Calendar Year in accordance with the Schedules of Benefits, including laboratory tests, x-rays and routine immunizations and inoculations against childhood diseases.

28. **Hospice care** expenses as described in *Benefits for Hospice Care.*

29. **Breast reconstruction following a mastectomy** - The Plan will provide coverage for the following medical and surgical services provided to a Covered Person in connection with a mastectomy:

    a. Reconstruction of the breast on which the mastectomy has been performed.

    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

    c. Prostheses and physical complications relating to all stages of the mastectomy, including lymphedemas.

Plan benefits payable for these services and supplies are subject to all applicable deductibles and copay percentages.

30. Certain tests and procedures related to **screening for colorectal cancer**. To be covered, the following requirements must be met and certain limits apply.

    a. Any of the following colorectal cancer screening tests for Covered Persons who are age 50 and older when recommended by their Doctor:

        i. Fecal occult blood test (FOBT) annually; plus

        ii. Sigmoidoscopy (covered every 5 years for average risk patients); or

        iii. Double contrast barium enema (DCBE) (covered every 5 years for average risk patients); or

        iv. Colonoscopy (covered every 10 years for average risk patients).

    b. Screening with annual FOBT, either alone or in conjunction with sigmoidoscopy, beginning at age 50.

    c. Colorectal cancer screening beginning at age 40 for Covered Persons with a single first-degree relative (sibling, parent, or child) with a history of colorectal cancer or an adenomatous polyp.

    d. Screening with sigmoidoscopy, DCBE, or colonoscopy as frequently as every two years for individuals with one or more of the following high risk factors for colorectal cancer:

        i. First-degree relative (sibling, parent, child) who has had colorectal cancer or an adenomatous polyposis (screening covered beginning at age 40);

        ii. Family history of familial adenomatous polyposis (screening covered beginning at puberty);

        iii. Family history of hereditary nonpolyposis colorectal cancer (HNPCC) (screening covered beginning at age 20).

    e. Colorectal cancer surveillance with colonoscopy, flexible sigmoidoscopy or DCBE as frequently as every two years for Covered Persons who meet any of the following criteria:

        i. Patient has inflammatory bowel disease (including ulcerative colitis or Crohn's Disease);

        ii. Personal history of adenomatous polyps;

        iii. Personal history of colorectal cancer.

31. Charges for first aid treatment as described in the Schedule of Benefits.

COMPREHENSIVE MEDICAL EXPENSE BENEFIT EXCLUSIONS AND LIMITATIONS

No payments for Comprehensive Medical Expense Benefits will be made for charges incurred for:

1. Care or treatment provided to any person who is not eligible for benefits under the Plan on the date of the care or treatment or on the date charges are incurred as a result of the care or treatment.

2. Services or supplies that are not Medically Necessary for treatment of the injury or sickness involved.

3. Services or supplies received from any provider of medical services that does not meet the Plan's definition of Doctor or Hospital.

4. Services or supplies provided in connection with any injury or sickness for which a Covered Person is not under the regular care of a Doctor, or which are not recommended or approved by the attending Doctor.

5. Any charge or portion of a charge that is in excess of the amount considered to be a Reasonable and Customary Charge.

6. Services and/or procedures that are Experimental or Investigative in nature.

7. Services, supplies, treatments or procedures for which payment under the Plan is specifically excluded as stated elsewhere in this SPD.

8. Charges incurred that are in excess of any limitations stated in the Schedules of Benefits or in any other applicable portion of this SPD.

9. Care, treatments, services, or supplies for which Plan benefits would otherwise be provided but for which the Covered Person has already received Plan benefits totaling the applicable maximum benefit, allowance, or limitation during any specific time period for that type of care and treatment as stated in the Schedules of Benefits.

10. Services or supplies that are not provided for the treatment or correction of, or in connection with, a non-occupational accidental injury or sickness unless specifically noted as covered.

11. Private duty nursing care provided to a Covered Person who is confined in a Hospital, or nursing care or treatment provided by a person who normally lives in your home or the home of the Covered Person receiving the care, or by a close relative. A close relative is defined as you and your Spouse, and the Children, brothers, sisters and parents, of you and/or your Spouse.

12. Any type of physical test or examination (other than a routine physical) that is not Medically Necessary for treatment of an injury or sickness or where there have been no symptoms, except as stated in the *Covered Medical Expenses* section.

13. Services, supplies or treatments that are preventative in nature, except that this exclusion does not apply to routine inoculations or immunizations for Children.

14. Services, treatment and/or surgical procedures rendered in connection with an overweight condition or condition of obesity.

    Exception: Certain charges incurred for obesity will be covered if the Eligible Employee, Eligible Retiree or Spouse (Children are not eligible for this benefit) meets all of the following criteria:

    a. The person is 100% over his or her medically desirable weight as determined by the Medical Review Manager;

b. The obesity is a threat to the person's life due to other complicating health factors, such as diabetes, heart trouble, hypertension, etc. as determined by the Medical Review Manager; and

c. The person has a medical history of unsuccessful attempts to lose weight by other methods.

If the Covered Person meets all of the foregoing criteria, the Plan will cover (1) one course of weight loss treatment supervised by and utilizing medication prescribed by a Doctor, including any laboratory work associated with the weight loss treatment program, and (2) one surgical procedure for weight loss prescribed by a Doctor, including Medically Necessary laboratory charges. If the surgical procedure is performed in a PPO facility, covered charges will be paid at 70% of the usual, Reasonable and Customary Charge; if the surgical procedure is performed in a non-PPO Hospital, covered charges will be paid at 60% of the usual, Reasonable and Customary Charge. (The Plan does not cover surgical procedures performed at non-PPO network outpatient surgical facilities.) The covered charges incurred for such surgery will not apply towards the individual's or family's out-of-pocket limits.

15. Any treatment, service, supply, or surgical procedure that is elective and not Medically Necessary. This includes any non-emergency plastic or cosmetic surgery on the body, including but not limited to such areas as the eyelids, nose, face, breasts, or abdominal tissue.

However, this exclusion does not apply to:

a. Cosmetic surgery which is performed for the correction of defects incurred as a result of traumatic injuries sustained by a Covered Person; or

b. The correction of congenital defects; or

c. Corrective surgical procedures on organs of the body which perform or function improperly; or

d. Reconstructive breast surgery following a mastectomy, including reconstructive surgery on the non-affected breast to achieve a symmetrical appearance; or

e. Vasectomies, tubal ligations and other sterilization procedures performed on Covered Persons other than Children; or

f. Abortions performed on Covered Persons other than Children.

16. Reversal or attempted reversal of vasectomies or other sterilization procedures.

17. An abortion or complications of an abortion performed on a Child.

18. Contraceptive devices, injections or any other method of contraception other than covered surgical sterilization or oral birth control medications.

19. Any operation or treatment provided in connection with sex transformations or any type of sexual dysfunction including any complications arising from such conditions or situations.

20. Charges incurred for a surgical or other procedure of any type, including the use of laser technology, performed for the purpose of correcting nearsightedness, farsightedness or astigmatism.

21. Removal of an organ or part of an organ for donor purposes.

22. Travel or transportation, whether or not recommended or prescribed by a Doctor, except as stated in the *Covered Medical Expenses* section.

23. Treatment of Chemical Dependency other than as stated in the *Benefits for Treatment of Chemical Dependency* section.

24. Treatment of Mental or Nervous Disorders other than as stated in the *Benefits for Treatment of Mental or Nervous Disorders* section.

25. Treatment or consultation with a marriage counselor or in connection with marriage counseling, except as provided through the Employee Assistance Program.

26. Services rendered by a social worker. However, this exclusion does not apply to:

    a. covered services provided by a social worker under an approved and elected program of Hospice care; or

    b. services provided by a social worker for outpatient treatment of Chemical Dependency or a Mental or Nervous Disorder if the services are provided on the recommendation of and under the direct supervision of a psychiatrist (M.D.) or a licensed clinical psychologist; or

    c. services provided through the Employee Assistance Program.

27. Any of the following items, whether or not prescribed, recommended or provided by a health care practitioner: food products, diet or hair analysis, pillows, supports or other similar products, and booklets, pamphlets or other educational material, or breast pumps, chiropractic braces, commodes, communication devices, elevators or stair lifts, air conditioners, air purifiers, humidifiers, dehumidifiers, electric heating units, blood pressure instruments, stethoscopes, clinical thermometers, scales, devices or surgical implantations for stimulating natural body contours, exercise equipment, vibratory equipment, health club memberships, or whirlpools or pools. The Plan will cover Neocate infant formula during the first year of life provided the Plan determines that the use of such formula is Medically Necessary. The Plan will pay 50% of the Reasonable and Customary Charge, and such benefit payments are not subject to the Calendar Year deductible, nor will they be applied towards satisfaction of the Calendar Year out-of-pocket limit.

28. Services or supplies provided in connection with smoking cessation including but not limited to therapy, counseling, acupuncture, stop-smoking programs, hypnosis, tapes, records, videos, or medications, whether prescription or non-prescription, such as nicotine gum or patches, or any other habit-breaking medications.

29. Room and board, care, treatment, supplies or services (including professional services) provided or rendered while a Covered Person is confined in an institution or facility that is primarily a place of rest, a place for the aged, or a nursing home, convalescent home or similar facility, unless the facility meets the Plan's definition of a "Skilled Nursing Facility" and all of the necessary criteria stated in the *Covered Medical Expenses* section.

30. Room and board, care, treatment, services or supplies provided during a Hospital confinement or a confinement in any other facility that is for any type of custodial care. "Custodial care" means care that is designed primarily to assist a Covered Person in meeting the activities of daily living. Custodial care will not be considered to be provided when room, board, and skilled nursing services must be combined with other Medically Necessary therapeutic services and supplies according to generally accepted medical standards to establish a medical treatment program. However, for treatment, services, or supplies not to be considered to be for custodial care, the services and supplies must be provided to a Covered Person in a facility for which Plan coverage

is available, and the program of medical treatment must be one which can reasonably be expected to substantially improve the Covered Person's medical condition.

31. Special education, including but not limited to diabetes education, provided to a Covered Person, regardless of the type or purpose of the education, the recommendation of the attending Doctor, or the qualifications of the persons providing the education.

32. Educational or I.Q. evaluations, or education, training or room and board while a Covered Person is confined in an institution that is primarily a school or other institution for learning or training whether or not such confinement is prescribed or recommended by a Doctor or is otherwise Medically Necessary.

33. Dental surgery, treatment, x-rays or any other care or treatment of the teeth and/or gums, except those expressly stated in the *Covered Medical Expenses* section; or eye refraction, eyeglasses and their fitting except as stated under the provisions of the *Vision Expense Benefit.*

34. Any injury or sickness that, in the sole judgment of the Trustees, and based on available evidence, was sustained in the course of, or was contributed to by, the Covered Person's commission or attempted commission of a felony, whether or not such Covered Person is convicted of a crime.

35. Treatment of bodily injury or sickness caused by war or any act of war, whether war is declared or undeclared; any act of international armed conflict; any conflict involving the armed forces of any international body; insurrection; participating in a riot; or terrorist attack.

36. Services or supplies rendered while the Covered Person is confined in a Hospital operated by the U.S. Government or an agency of the US. Government, except that the Plan, to the extent required by law, will reimburse a V.A. hospital for the "reasonable cost" of care for a non-service-related disability if the Plan would normally cover such care if the V.A. weren't involved.

37. Charges incurred that would not have been made if the Plan did not exist; or for any medical care, service or Hospital confinement (except with respect to a VA hospital confinement) for which a Covered Person would not be legally required to pay; or for services or supplies which are furnished, paid for or otherwise provided due to past or present service of any person in the armed forces of a government.

38. The completion of claim forms (or forms required by the Plan for the processing of claims) by a Doctor or other provider of medical services or supplies.

39. Charges for services or supplies provided outside the United States and its territories and protectorates.

40. Speech Therapy for functional purposes such as speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin or childhood developmental speech delays or disorders.

41. Vision Therapy (orthoptics) services.

42. Massage Therapy.

43. Pregnancy or pregnancy-related conditions of Children.

44. Travel expenses except for Medically Necessary transportation or professional ambulance services.

EMPLOYEE ASSISTANCE PROGRAM

The Plan provides an Employee Assistance Program (EAP) through the Mental Health and Chemical Dependency Review Manager.

- The EAP provides confidential assistance with a variety of personal or workplace problems such as stress, depression, grief and marital difficulties, at no cost to you.
- The Plan provides up to six (6) EAP sessions per problem per Calendar Year at no cost to you. The number of EAP sessions that you use will depend on the EAP Specialist's assessment of your needs. Though these EAP sessions are provided to you and your Dependents at no cost to you, your sessions must be preauthorized by calling the EAP's toll-free telephone number.

The EAP also maintains a wellness website that can provide you and your family with valuable information and resources to assist in the daily demands of work and home. The website has information on how to access the EAP program and an outline of the Plan's benefits for Mental Health and Chemical Dependency treatment.

BENEFITS FOR TREATMENT OF CHEMICAL DEPENDENCY

LIMITATIONS AND MAXIMUM BENEFITS

Each Covered Person may receive inpatient or outpatient treatment of Chemical Dependency. Benefits paid under any Plan shall apply towards all maximums including the Chemical Dependency Benefit, applicable to all Plans.

Benefits will be reduced or denied for inpatient treatment that has not been precertified by the Mental Health and Chemical Dependency Review Manager that has been determined to be Medically Necessary.

PROVISIONS GOVERNING TREATMENT OF CHEMICAL DEPENDENCY

1. You must follow the procedures of the *Mental Health and Chemical Dependency Precertification Program* if treatment is proposed or received. If you do not, your benefits will be reduced or denied.

2. Inpatient treatment must be received in, and outpatient treatment must be provided by or through, an approved facility. An inpatient admission to an approved facility must be at a Doctor's direction.

   An approved facility is a Hospital or other facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or that is licensed by the state to provide treatment of Chemical Dependency, or that is approved by the Mental Health and Chemical Dependency Review Manager in the course of precertifying the treatment as Medically Necessary.

3. Outpatient treatment may only be provided by a:

   a. psychiatrist (M.D.);

   b. licensed clinical psychologist; or

c. psychologist, counselor or social worker rendering treatment upon the recommendation of and under the direct supervision of a psychiatrist (M.D.) or licensed clinical psychologist.

4. Outpatient therapy includes individual, group and family therapy.

EXCLUSIONS AND LIMITATIONS ON TREATMENT OF CHEMICAL DEPENDENCY

No payments will be made for charges incurred for:

1. inpatient treatment that is not determined to be, and is not precertified by the Mental Health and Chemical Dependency Review Manager as Medically Necessary; or

2. treatment provided in or through a facility that is not an approved facility; or

3. outpatient treatment provided other than by a psychiatrist (M.D.) or licensed clinical psychologist, or a psychologist, counselor or social worker rendering treatment upon the recommendation of and under the direct supervision of a psychiatrist (M.D.) or licensed clinical psychologist; or

4. smoking cessation treatment or programs; or

5. services that are in excess of any limitations stated in this SPD, or that are in excess of any limitations stated in the Schedules of Benefits, or that are excluded from coverage in the *Plan Conditions, Limitations and Exclusions* section.

BENEFITS FOR TREATMENT OF MENTAL OR NERVOUS DISORDERS

LIMITATIONS AND MAXIMUM BENEFITS

Each Covered Person may receive inpatient or outpatient treatment of mental or nervous disorders. Benefits paid under any Plan shall apply towards all maximums including the Mental or Nervous Disorder Benefits applicable to all Plans.

Benefits will be reduced or denied for inpatient treatment that has not been precertified by the Mental Health and Chemical Dependency Review Manager that has been determined to be Medically Necessary

PROVISIONS GOVERNING TREATMENT AND BENEFITS FOR MENTAL OR NERVOUS DISORDERS

1. You must follow the procedures of the *Mental Health and Chemical Dependency Precertification Program* if any inpatient or partial inpatient treatment is proposed or received. If you do not, your benefits will be reduced or denied.

2. Benefits are payable for inpatient care and for partial inpatient care that is provided as an alternative to full-time inpatient care, or as a transition from inpatient to outpatient care.

3. Inpatient and partial inpatient treatment must be received while you are confined in or being treated in an approved facility for treatment of Mental or Nervous Disorders.

   An approved facility is a Hospital or other facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or that is licensed by the state to provide treatment of Mental Health and/or Chemical Dependency, or that is approved by the Mental Health and Chemical Dependency Review Manager in the course of precertifying the treatment as Medically Necessary.

4. Benefits for inpatient and partial inpatient care are payable the same as for any other sickness, subject to all applicable limitations shown in the Schedules of Benefits.

5. Covered outpatient treatment may only be provided by a:

   a. psychiatrist (M.D.);

   b. licensed clinical psychologist; or

   c. psychologist, counselor or social worker rendering treatment upon the recommendation of and under the direct supervision of a psychiatrist (M.D.) or licensed clinical psychologist.

6. Therapy may include individual, group, or family therapy.

EXCLUSIONS AND LIMITATIONS ON TREATMENT OF MENTAL OR NERVOUS DISORDERS

No payments will be made for charges incurred for:

1. inpatient treatment that that has not been precertified by the Mental Health and Chemical Dependency Review Manager that it has determined it to be Medically Necessary;

2. treatment by or consultation with a marriage counselor, or in connection with marriage counseling; or

3. treatment provided in or through a facility that is not an approved Hospital or facility; or

4. outpatient treatment provided other than by a psychiatrist (M.D.) or licensed clinical psychologist, or a psychologist, counselor or social worker rendering treatment upon the recommendation of and under the direct supervision of a psychiatrist (M.D.) or licensed clinical psychologist; or

5. consultations or sessions with other family members even if the consultations or sessions are required as part of another family member's psychological or psychiatric treatment unless the family member being treated is present at the consultation or session; or

6. charges that are in excess of any limitations stated in this SPD or that are in excess of any limitations stated in the Schedules of Benefits, or that are excluded from coverage in the *Plan Conditions, Limitations and Exclusions* section.

BENEFITS FOR HOSPICE CARE

Hospice care is a special program of care provided for individuals with terminal medical conditions. This program provides a system of care that allows a terminally ill individual to continue life with minimal disruption in normal activities while remaining primarily in the home environment. Plan benefits are payable for services and supplies provided to a Covered Person receiving Hospice care only in accordance with the provisions described in this section.

PROVISIONS GOVERNING HOSPICE CARE

1. A Covered Person wanting to receive Hospice care must elect to receive benefits under the Hospice care benefit instead of under the Comprehensive Medical Expense Benefit. Before any Hospice care is provided, the election form must be submitted through the Hospice from which the Covered Person elects to receive Hospice care. A Covered Person who elects to be covered under the Hospice care benefit waives his or her right to the Comprehensive Medical Expense Benefit for treatment of his or her terminal condition and will receive any and all treatment of his or her terminal condition, palliative care, and direct care of the terminal condition under the Hospice care benefit except for long-term inpatient care or surgical operations or Hospital confinements due to medical complications of the terminal condition. However, an election of Hospice care may be revoked at anytime by the Covered Person (or by someone authorized to act on his or her behalf). Once Hospice care is revoked, no further Hospice care would be provided under the Hospice Care benefit and benefits for any further care and treatment of the terminal individual's condition would be provided under the Comprehensive Medical Expense Benefit, subject to all applicable limitations and exclusions. Benefits paid under any Plan shall apply towards all maximums including the Hospice Care Benefit, applicable to all Plans.

2. A Doctor must certify that a Covered Person's medical condition is terminal (a prognosis indicating a life expectancy of 6 months or less) and this certification must take place no later than 2 days after the individual begins Hospice care. This certification may be performed by the Hospice Care Doctor if the Covered Person is using that Doctor as his primary Doctor; otherwise, both the Hospice Care Doctor and the Covered Person's primary Doctor must certify the terminal diagnosis, otherwise no benefits are payable for Hospice care.

3. A Covered Person who elects to receive treatment under the Hospice care benefit will be entitled to Hospice care benefits during the remainder of his or her lifetime, subject to the Hospice care lifetime maximum and to other applicable limitations specified in the Schedule of Benefits.

4. All benefits paid by the Plan for Hospice care will apply against the Hospice care benefit lifetime maximum.

5. Once a Covered Person has received Hospice care benefits that total the Hospice care benefit lifetime maximum, no further Hospice care benefits will be payable on behalf of the Covered Person. Any benefits for further care and treatment of the Covered Person's terminal condition will be provided under the Comprehensive Medical Expense Benefit, subject to all applicable limitations and exclusions.

6. Only expenses incurred for Hospice care of a Covered Person's terminal condition apply under the Hospice care benefit.

7. If a terminally ill Covered Person incurs expenses for long-term inpatient care or surgical operations or Hospital confinements due to medical complications of his or her terminal condition, benefits for such expenses will not apply under the Hospice care benefit but will be considered for payment under the Comprehensive Medical Expense Benefit.

8. If a terminally ill Covered Person incurs expenses for treatment of an injury or sickness totally unrelated to the terminal condition, benefits for such expenses will be considered for payment under the Comprehensive Medical Expense Benefit.

9. All benefits for charges incurred under the Hospice care benefit will automatically be assigned and payable to the Hospice provider.

10. Hospice care benefits are only payable for the following services and supplies called "core services":

    a. Nursing care by an R.N. or L.P.N. and services of homemakers and home health aides. Such services may be furnished up to six hours per day or on a 24-hour basis during a period of crisis or if the care is necessary to maintain the patient at home. A period of crisis is a period during which a terminally ill individual requires continuous care that is predominantely provided by a licensed nurse. This care must be necessary to achieve palliation or management of acute medical services; and

    b. Chaplaincy, medical social services and counseling services and/or psychological therapy by a social worker or a psychologist; and

    c. Physical therapy, occupational therapy and speech language pathology; and

    d. Non-prescription drugs used for palliative care (care provided to a terminally ill individual for the purpose of relieving or alleviating symptoms without curing), medical supplies, bandages and equipment, and drugs and biologicals used for pain and symptom control; and

    e. Skilled nursing facility short-term inpatient care to provide respite care (short-term care provided to a terminally ill individual only when necessary to relieve family members caring for the individual), palliative care or care in periods of crisis.

HOSPICE CARE EXCLUSIONS AND LIMITATIONS

No Hospice care benefits will be paid for the following:

1. Bereavement counseling for the family after the Covered Person's death;

2. Administrative services;

3. Child care and/or housekeeping services;

4. Transportation expenses;

5. Long-term inpatient care, surgical operations or Hospital confinements due to medical complications of the terminal condition. However, these expenses will be considered for payment under the Comprehensive Medical Expense Benefit;

6. Any services or supplies provided for treatment of any injury or sickness other than the terminal condition. However, these expenses will be considered for payment under the Comprehensive Medical Expense Benefit; or

7. Any Services or supplies not provided as "core services" by the Hospice providing the Hospice care.

PRESCRIPTION DRUG PROGRAM

The Plans provide three cost-saving programs for prescription drugs:

- The Retail Pharmacy Card Program;
- The Maintenance Choice Program; and
- The Specialty Pharmacy Program.

The Prescription Drug Program is administered by a prescription drug benefit management company in accordance with a contract with the Plan. Together, the Retail Pharmacy Card Program, the Maintenance Choice Program, and the Specialty Pharmacy Program provide comprehensive coverage for your prescription drug needs. To find a participating retail pharmacy or information on the Maintenance Choice Program, or Specialty Pharmacy Program, contact the prescription drug benefit management company. The prescription drug benefit management company determines whether a drug is a long-term or maintenance medication. All state and federal laws are followed in the dispensing of all medications.

RETAIL PHARMACY CARD PROGRAM

Retail pharmacies that participate in the Retail Pharmacy Card Program have agreed to charge special contracted prices to Plan participants. Since these contracted prices are often lower than the pharmacy's regular retail prices, your out-of-pocket cost may be lower.

- When the Doctor prescribes a drug for short-term or acute usage, go to a participating retail pharmacy and use your Prescription Drug Program I.D. card to make your purchase.
- You will be required to pay 20% of the contracted price directly to the participating retail pharmacy. The Plan will pay the rest.
- Your 20% copay percentage amounts do not apply to any Plan deductibles or out-of-pocket limits.
- There are no claims or forms to file.
- Each time you purchase a Covered Prescription Drug at a participating retail pharmacy, you can get up to a 30-day supply, or the quantity prescribed by the Doctor, whichever is less. You may only obtain refills that are authorized by a Doctor.
- After you have purchased the initial supply plus one refill (if authorized by a Doctor) of a long-term or maintenance medication, you must use the Maintenance Choice Program for all additional authorized refills.

If the Doctor prescribes a drug that must be taken on a long-term basis, ask the Doctor for two prescriptions - one for a 30-day supply that you can have filled immediately at a participating retail pharmacy, and one for up to a 90-day supply (plus any authorized refills) that you can obtain through the Maintenance Choice Program.

MAINTENANCE CHOICE PROGRAM

Under the Maintenance Choice program, you have the option of picking up your long-term or maintenance medication at any CVS Pharmacy or receiving it from the mail service pharmacy. Either

way you pay the same copayment and the prescription drugs will be provided at contracted (discounted) prices to the Fund.

- Use the Maintenance Choice Program for long-term or maintenance drugs. These are drugs to be used on an ongoing basis for conditions such as high blood pressure, high cholesterol, arthritis, diabetes, etc. You should use the Retail Pharmacy Card Program if your prescription is for a drug prescribed for immediate and/or short-term usage, for example, if you are going to need the drug right away or for 60 days or less.

- You can order, subject to the Doctor's prescription, up to a maximum of a 90-day supply of a prescribed long-term or maintenance drug, or refills of such drug. Each time you have a prescription filled (or refilled) you pay either a CVS Pharmacy or the mail service pharmacy the copay amount shown in the Schedule of Plan Benefits. The Plan pays 100% of the remaining cost.

- You will receive a patient profile form and return envelope with your information packet from the mail service pharmacy. Send the Doctor's written prescription along with a completed patient profile form and your copay directly to the mail service pharmacy. If applicable, you will receive a prescription refill form with your first filled order.

You must pay the copay amount each time a prescription is filled (or refilled). You will save money if the Doctor prescribes your long-term or maintenance medications in 90-day quantities.

- Neither your copays nor the actual benefits paid by the Plan under this program will be applied to the Comprehensive Benefit deductibles or out-of-pocket limits.

IF OTHER COVERAGE IS INVOLVED

Prescription Drug Program benefits cannot be coordinated with any benefits provided under other health care plans.

SPECIALTY PHARMACY PROGRAM

This Specialty Program applies to injectable medications and other medication therapies involving complex administration methods, expensive or difficult-to-find medications, and drugs requiring special storage, handling, and delivery (referred to as "specialty medications"). While the Fund's pharmacy benefit management company reviews all specialty medications for safe and appropriate use, under the Specialty Pharmacy Program as of the date of this SPD, medications used on an ongoing basis to treat the following chronic conditions are considered to be specialty medications and require prior approval before they will be covered by the Plan:

- Age Related Macular Degeneration;
- Allergic asthma;
- Alpha-1 Antitrypsin Deficiency;
- Cerebrospinal Fluid (CSF);
- Cystic Fibrosis;
- Enzyme replacement;
- Erythropoietin (EPO);
- Growth hormone & related disorders
- Hemophilia;
- Immune Therapies;
- Infertility;
- Inflammatory Bowel Disease (IBD);
- Multiple Sclerosis;
- Osteoarthritis;
- Osteoporosis;
- Psoriasis;
- Pulmonary Arterial Hypertension;
- Renal disease;

- Hepatitis C;
- HIV;
- Hormonal therapies;
- Respiratory Syncytial Virus; and
- Rheumatoid Arthritis.

If you or a Dependent need a specialty medication for a condition covered under the Specialty Pharmacy Program, you must have your prescription approved by the pharmacy benefit manager and filled through the Plan's Specialty Pharmacy Program. If your prescription is not approved under the Specialty Pharmacy Program, your specialty medication will not be covered under the Plan.

If you are currently taking a medication for a condition covered under the Specialty Pharmacy Program, the pharmacy benefit manager will contact you directly. In the future, if your Doctor issues a prescription to treat a condition described above, or for a specialty medication, your pharmacist will notify you at the time your prescription is being filled that you must contact the pharmacy benefit manager

Once you are in contact with the pharmacy benefit manager, a representative will work with you and your Doctor to determine if the prescribed medication is covered under the Plan. If your medication is not approved as a Covered Expense, the pharmacy benefit manager will work with you and/or your Doctor to identify possible alternatives that may be covered by the Plan. Note, that the pharmacy benefit manager will decide all claims for benefits under the Specialty Pharmacy Program. If your claim for benefits is denied in whole or in part by the pharmacy benefit manager, you may request a full and fair review by filing a written notice of appeal with the Board of Trustees, as outlined in the section entitled, *Denial of Claims.*

The Specialty Pharmacy program provides you with personalized pharmacy care management services, including:

- access to staff pharmacists, available 24 hours a day, 7 days a week;
- convenient, prompt, and discreet delivery – the pharmacy benefit manager will deliver your prescription directly to you or to your Doctor's office;
- disease-specific education and counseling;
- refill reminder phone calls;
- coordination of your medication needs among you, your Doctor, and the Plan;
- website support which includes access to disease specific information and to pharmacists and nurses.

EXCLUSIONS AND LIMITATIONS

Covered Prescription Drug Expenses are charges for drugs and medications for which a Doctor has provided a written prescription and that are not otherwise excluded under the Plan. Covered Prescription Drug Expenses under this program do not include:

1. Any products, drugs or medications that can be obtained without a Doctor's written prescription, even though a Doctor has prescribed them; or

2. Experimental or Investigative drugs or medications and prescription drugs not approved for use by the U.S. Food & Drug Administration (FDA); or

3. Growth hormones, unless precertified by the Medical Review Manager that it has determined it to be Medically Necessary for the treatment of an illness; or

4. Products, drugs or medications that are prescribed to treat mental or physical conditions for which the products, drugs or medications are not approved by the FDA, or that are not prescribed or used in a manner consistent with the FDA's intended and approved usage; or

5. Drugs or medications which are used for or in connection with any type of treatment or condition for which benefits are excluded under the Plan, even though such drugs or medications are obtained with a Doctor's prescription; or

6. Drugs or medications that are excluded from coverage under any other provision or rule of the Plan, including but not limited to the provisions in the *Plan Conditions, Limitations and Exclusions* section.

DENTAL EXPENSE BENEFITS - PLANS II AND III

Dental Expense Benefits include an Orthodontia Expense Benefit and a Periodontal Expense Benefit and are only available under Plans II and III.

DENTAL PREFERRED PROVIDER ORGANIZATION (DENTAL PPO)

To keep your dental expenses down, the Fund has contracted with a dental preferred provider organization (Dental PPO) that charges negotiated rates for services. When you and your Dependents use a Dental PPO network dentist, your expenses will be lower than if you use a dentist who is not in the Dental PPO network.

The copay percentages that you pay for certain services after meeting the dental Calendar Year deductible will be the same whether you use a PPO network dentist or a Non-PPO dentist. However, if you use a PPO network dentist, the dental charges to which your copay percentages are applied will be lower than if you used a Non-PPO dentist because PPO network dentists charge a lower rate for their services than Non-PPO dentists.

DENTAL EXPENSE BENEFIT – HOW IT WORKS

INDIVIDUAL AND FAMILY CALENDAR YEAR MAXIMUM BENEFITS

You and your Dependents are entitled to dental benefits each Calendar Year up to the maximum benefit per Covered Person shown in the Schedules of Benefits. After the Covered Persons in your family have received dental benefits during a Calendar Year totaling the family maximum benefit, no further benefits will be payable for anyone in your family for the remainder of that Calendar Year.

The maximum benefits and the Plan payment percentages for the various types of Covered Dental Expenses are shown in the Schedules of Benefits.

INDIVIDUAL AND FAMILY CALENDAR YEAR DEDUCTIBLES

The following rules apply to the Dental Expense Benefit deductible:

1. The Dental Expense Benefit Calendar Year Deductible per person will apply only to Covered Dental Expenses incurred for Basic Dental Services and denture replacement.

2. If a Covered Person incurs Covered Dental Expenses for Basic Dental Services and/or for denture replacement during a Calendar Year, such incurred expenses will be reduced by the amount of the deductible before the benefit payable by the Plan is determined.

3. Once a Covered Person's Covered Dental Expenses incurred for Basic Dental Services and/or denture replacement equal the amount of the deductible during a Calendar Year, the Plan will then pay the applicable copayment percentage of that Covered Person's Covered Dental Expenses that are in excess of the Calendar Year deductible.

4. Each Covered Person must satisfy the deductible each Calendar Year before the copayment percentage of any additional Covered Dental Expenses are payable under the Plan, except that if

the Deductible has been satisfied during a Calendar Year by three (3) eligible family members of one family, no further Deductibles will be required of that family for that Calendar Year.

5. Only charges incurred for Basic Dental Services and/or denture replacement which are considered to be Covered Dental Expenses may be used to satisfy the deductible.

6. If Covered Dental Expenses incurred during October, November, or December of a Calendar Year are applied to a Covered Person's deductible for that Calendar Year, the Covered Person's deductible for the following Calendar Year will be reduced by the amount applied in the previous October, November, or December.

7. The Dental Expense Benefit deductible cannot be used to satisfy any part of any applicable Comprehensive Medical Expense Benefit deductibles.

Covered Dental Expenses

Covered Dental Expenses are the discounted or Reasonable and Customary Charges incurred for the following:

Routine Services (100% Plan Payment)

Provided once each in any period of six (6) consecutive months (no deductible).

1. Routine oral examination, diagnosis, and necessary dental x-rays.

2. Prophylaxis (cleaning of teeth) by a Dentist or a dental hygienist working under the direction and supervision of a Dentist.

3. Topical application of fluoride (Children under age 19 only).

Basic Dental Services (80% Plan Payment) - (Subject to the deductible)

1. Oral examinations (other than routine or orthodontic), diagnoses, necessary dental x-rays, and extractions (other than related to orthodontic treatment).

2. Oral surgery for which medical benefits are not payable and for which no other dental benefits are payable, unless the surgery is excluded under the Plan.

3. Restoration and replacement of the loss of natural teeth and natural tooth structure by use of a filling, bridge or partial denture, or by an inlay or crown made of acrylic resin or porcelain. If gold is used, the Covered Dental Expense will be the amount allowed if acrylic resin or porcelain had been used.

4. General anesthetics when Medically Necessary and administered in connection with oral or dental surgery, and injection of antibiotic drugs by the attending Dentist.

5. Endodontic treatment (including root canal therapy), and treatment of periodontal and other diseases of the gums and mouth tissues (unless a particular type of service is covered under the Periodontal Expense Benefit).

6. Repair of fillings, bridges, dentures (partial or complete), inlays or crowns.

7. Space maintainers to replace prematurely lost teeth.

8. Emergency dental care.

9. The first installation in a Covered Person's mouth of a complete denture replacing the loss of the natural teeth and associated structure.

10. Sealants for Children under age 19, when applied to permanent molars with no caries or restorations, one per tooth during the Child's lifetime.

Complete Denture Replacement (50% Plan Payment) - (Subject to the deductible)

Expenses incurred for complete denture replacement are covered only under the following circumstances:

1. The existing denture cannot be made serviceable and replacement is recommended as necessary by a Dentist; and

2. The Covered Person has been covered under the Plan for at least 12 consecutive months; and

3. If expenses for the previous denture were payable under the Plan, at least 60 consecutive months have passed since the Covered Person received the previous denture; and

4. The replacement must not be due to loss or theft of a denture.

DENTAL BENEFIT EXCLUSIONS AND LIMITATIONS

No payment will be made for the following:

1. For charges incurred after an individual has received dental benefits for Covered Dental Expenses incurred during a Calendar Year totaling the individual maximum benefit, or for any member of his family after his family has received dental benefits for Covered Dental Expenses incurred during that Calendar Year totaling the family maximum benefit.

2. For orthodontic treatment (see the Orthodontia Expense Benefit).

3. For any dental procedures performed as a result of a injury to sound natural teeth for which benefits are payable under the Comprehensive Medical Expense Benefit.

4. For treatment of periodontal disease (see the Periodontal Expense Benefit).

5. For services, supplies or appliances that are primarily cosmetic in nature, including bleaching.

6. For personalization or characterization of dentures; replacement of a lost, missing or stolen prosthetic device; any duplicate prosthetic device or other duplicate appliance; plaque control programs; oral hygiene and/or dietary instruction; bonding (unless bonding is Medically Necessary); or any other service or supply which is not reasonably necessary for dental care and treatment.

7. Dental implants and all related services.

8. For extraction of partially or wholly bony impacted wisdom teeth or charges incurred in conjunction with these services.

9. For charges incurred prior to the date a person began Covered Employment for the treatment of:

- full or partial dentures;
- fixed bridgework, crowns and other gold restorations; and
- root canal therapy.

10. For charges related to tooth preparations and impressions for prosthetic devices (including bridges, crowns, or dentures) that were incurred prior to the date a Covered Person began Covered Employment.

11. For endodontic treatment performed more than 90 days after a person's eligibility for dental benefits terminates, even if the tooth was opened for root canal therapy while the person was eligible for dental benefits under the Plan.

12. For any treatments, care, services or supplies that are stated as limited or not payable in this Dental Expense Benefit explanation, or that are stated as limited or not payable in the *Plan Conditions, Limitations and Exclusions* section, or that are in excess of any maximum benefits shown in the Schedules of Benefits.

EXTENSION OF DENTAL BENEFITS

If a person's eligibility for dental benefits terminates, the following dental benefits only will be extended for the terminated person for up to 90 days:

1. For *fillings, bridgework, crowns or gold restorations*, if the tooth was prepared while the person was eligible for dental benefits; and

2. For *full or partial dentures*, if the impression for the appliance was taken while the person was eligible for dental benefits; and

3. For *endodontic treatment*, if the tooth was opened for root canal therapy while the person was eligible for dental benefits.

ORTHODONTIA EXPENSE BENEFITS - PLANS II AND III

LIFETIME MAXIMUM ORTHODONTIA BENEFITS

You and your Dependents are each entitled to a lifetime maximum benefit for orthodontic treatment. Once a Covered Person has received orthodontia benefits totaling his or her lifetime maximum benefit, he or she will not be entitled to any further orthodontia benefits. There is no deductible. Orthodontic services normally consist of a diagnostic workup, dental x-rays, tooth extraction, installation of appliances and adjustments of the appliances (maintenance).

PAYMENT PROVISIONS

Subject to the lifetime maximum as specified in the Schedules of Benefits for Plans II and III, the Plan will pay 50% of the discounted or Reasonable and Customary Charge of the Covered Orthodontia Expenses incurred by a Covered Person according to the following provisions:

1. The initial Plan payment will be made upon the installation of necessary orthodontic appliances and will be the lesser of the amount actually billed by the provider for the preliminary diagnostic work-up and initial banding or 25% of the total fee for the plan of treatment.

2. Payment for subsequent charges will be made as billed until the treatment has been completed or the Orthodontia lifetime maximum has been reached, whichever occurs first.

3. In addition to your 50% share of the Covered Orthodontia Expenses, you will have to pay any charges that are more than the discounted or Reasonable and Customary charge and for any charges that are not covered by the Plan.

4. If a Covered Person is already undergoing orthodontic treatment when his coverage for orthodontia benefits starts, the Plan will pay 50% of the discounted or Reasonable and Customary Charges up to the lifetime maximum that are incurred on or after the date such coverage starts.

COVERED ORTHODONTIA EXPENSES

Covered Orthodontia Expenses are the discounted or Reasonable and Customary Charges incurred for:

1. an oral examination and diagnosis; and

2. initial and subsequent (if any) installation of necessary orthodontic appliances and retainers, and adjustment of orthodontic appliances; and

3. all other orthodontic treatment required by accepted orthodontic practice, including necessary tooth extractions and dental x-rays.

ORTHODONTIA BENEFIT EXCLUSIONS AND LIMITATIONS

No payment will be made for the following:

1. For services or supplies that are covered in whole or in part under any other Plan benefits; or

2. For replacement of lost or stolen appliances or retainers; or

3. For repair of broken appliances or retainers; or

4. For any treatments, care, services or supplies that are in excess of any limitations stated in the Schedules of Benefits, that are stated as limited or excluded in this SPD/Plan or that are stated as limited or excluded in the *Plan Conditions, Limitations and Exclusions* section.

TERMINATION OF ORTHODONTIA BENEFITS

All orthodontia benefits will terminate on the date that a person's eligibility for the Orthodontia Expense Benefit terminates.

PERIODONTAL EXPENSE BENEFITS - PLANS II AND III

LIFETIME PERIODONTAL MAXIMUM BENEFIT

You and your Dependents are each entitled to the lifetime maximum benefit set forth in the Schedules of Benefits for Plans II and III for periodontal treatment. There is no deductible.

COVERED PERIODONTAL EXPENSES

Subject to the lifetime maximum, the Plan will pay 80% of the discounted or Reasonable and Customary Charges shown in the Schedules of Benefits for Plans II and III incurred for the following procedures:

Gingivectomy or gingivoplasty	Mucogingival surgery
Gingival curettage	Osseous surgery
Gingival Flap	Periodontal scaling & root planning

Any of the above procedures that are performed on **less than a quadrant** will be considered a Basic Dental Service and will be payable under the Dental Expense Benefit only; no benefits will be payable under the Periodontal Expense Benefit.

In addition to your 20% copayment percentage of the Covered Periodontal Expenses, you will have to pay any charges that are more than the discounted or Reasonable and Customary charge and for any charges that exceed the Periodontal Lifetime Maximum Benefit.

PERIODONTAL EXPENSE BENEFIT EXCLUSIONS AND LIMITATIONS

No payment will be made for charges:

1. for any treatments, care, services or supplies that are in excess of any limitations stated in the Schedules of Benefits, that are stated as limited or excluded in this SPD or that are otherwise stated as limited or excluded in this section regarding Periodontal benefits.

2. for charges incurred for treatment, services, or supplies that are covered in whole or in part under any other benefit provided under the Plan.

NO EXTENSION OF PERIODONTAL EXPENSE BENEFITS

All Periodontal Expense Benefits will terminate on the date that a Covered Person's eligibility for the Periodontal Expense Benefit terminates.

VISION CARE EXPENSE BENEFIT – PLANS II AND III

The Roofers' Unions Welfare Trust Fund has contracted with a vision care network of providers to provide Covered Persons with vision benefits. Network providers include select private practitioners and optical retailers.

Covered Vision Care Expenses include charges for an eye examination performed by an ophthalmologist or optometrist, lenses and frames, and contact lenses, as outlined in the Schedules of Benefits for Plans II and III.

NETWORK BENEFITS

As described in the Schedules of Benefits, when you use network providers, you pay a copay per service or supply, and then the Plan pays the specific allowance for Covered Expenses. You pay any amounts that exceed the allowances; however, network providers offer discounted prices on many services and supplies.

When you become covered under Plan II or Plan III, you will receive an information packet, including two ID cards, from the vision care network. When you use network providers and show your vision care ID card, you do not need to file claims with the vision care network or the Fund Office.

NON-NETWORK BENEFITS

Non-network benefits are available, as outlined in the Schedules of Benefits for Plans II and III. If you use a provider that does not participate in the vision care network of providers, you must pay the non-network provider the full cost for any services or supplies when you receive them and then submit a claim to the vision care network for reimbursement.

The Plan pays specific allowances for covered non-network expenses. Any amounts that exceed the Plan allowances will not be covered under the Plan and are not available at discounted prices.

VISION CARE BENEFIT EXCLUSIONS AND LIMITATIONS

The Plan will not pay for the following:

- Charges for services or supplies obtained while a person was not covered under the Vision Expense Benefit;
- Services or supplies that are not reasonably necessary for the examination or correction of a Covered Person's defect of vision, that are not considered Covered Vision Care Expenses, or that are included in whole or in part as Covered Medical Expenses under any other portion of the Plan;
- For special supplies, such as subnormal vision aids, safety lenses, or goggles;
- Contact lenses that are for cosmetic purposes (where no visual correction is needed); or

- Orthoptics (vision therapy), vision training, or aniseikonia.

EXTENSION OF VISION BENEFITS

If you have a vision examination while you are eligible for this Vision Care Benefit, the Plan will pay benefits for charges you incur for the covered supplies ordered at the time of, and as a result of the examination, even if the supplies are provided to you after your eligibility for the Vision Care Benefit terminates.

PLAN CONDITIONS, LIMITATIONS AND EXCLUSIONS

The following is a list of services and supplies for which Plan benefits are not payable or for which benefits are limited.

NO PLAN PAYMENT WILL BE MADE FOR ANY LOSS SUSTAINED AS A RESULT OF OR FOR CHARGES INCURRED FOR OR AS A RESULT OF:

1. Charges incurred by a Covered Person who is not eligible for Plan coverage at the time the charges are incurred.

2. Charges incurred for any nursing services or care provided by a person who normally lives in the home of a Covered Person.

3. Charges incurred for nursing services or care provided by a person who is a close relative of a Covered Person. For the purposes of this provision, a "close relative" means a Spouse, child, brother, sister, or parent of the Covered Person or the Covered Person's Spouse.

4. Charges incurred for patent medicines or other drugs that can be obtained without a Doctor's prescription or which can be purchased over the counter, and prescription or non-prescription vitamins, supplements, hair restorers or wrinkle removers whether or not recommended by a Doctor.

5. Charges incurred for supplies, services and/or procedures that are Experimental or Investigative in nature.

6. Charges incurred for treatment of any injury or sickness caused by a suicide, attempted suicide, or self-inflicted injury, while insane or whether or not due to a mental impairment of any kind, except under the Weekly Disability Benefit. However, for charges related to a suicide, attempted suicide, or self-inflicted injury under the Comprehensive Medical Expense Benefit, Mental Health Benefit, Chemical Dependency Benefit, the Employee Assistance Benefit, or any other medical related benefit provided under the Plan, such incurred charge will be payable if due to an underlying health condition such as a mental impairment.

7. Charges incurred, except under the Loss of Life Benefit, for the treatment of any injury or sickness which in the sole judgment of the Trustees, based on available evidence, was sustained in the course of, or contributed to, by a Covered Person's participation in a felony or attempted felony.

8. Charges incurred, except under the Loss of Life Benefit, for the treatment of any injury or sickness that is due to a Covered Person participating in an illegal occupation.

9. Charges incurred for any services, supplies, treatments, or procedures that is specifically excluded under any other provision of this SPD.

10. Charges incurred that are in excess of any limitations specified in the Schedules of Benefits or that are in excess of any other limitations specified in any other provision of this SPD.

11. Charges incurred that are in excess of the Plan's Reasonable and Customary Charges.

12. Charges incurred for any education including but not limited to diabetes and nutritional education provided to any Covered Person, regardless of the type of education, the purpose of the education, the recommendation of the attending Doctor, or the qualifications of the persons providing the education.

13. Charges that would not otherwise have been made if the Plan did not exist.

14. Charges incurred for any care, treatments, services, or supplies for Plan benefits that are normally provided but that are in excess of, or that are incurred after the Covered Person has already received Plan benefits totaling any applicable maximum benefit during any specific time period for that type of care and treatment as described in the Schedule of Benefits or in any other provision of this SPD.

15. Charges incurred, except under the Loss of Life Benefit, for the treatment of any injury or sickness caused by: war or any act of war, whether war is declared or undeclared; any act of international armed conflict; any conflict involving the armed forces of any international body; insurrection, or participating in a riot; or terrorist attack.

16. Charges incurred or loss sustained except under the Loss of Life Benefit, for the treatment of any injury or sickness, or disease sustained while a Covered Person was performing any act of employment, including self-employment, or doing anything pertaining to any occupation, employment or activity for remuneration or profit whether or not benefits are payable in whole or in part under any Workers' Compensation Law, Employer's Liability Law, Occupational Diseases Law, or similar law.

17. Charges incurred for services or supplies that are furnished, paid for, or otherwise provided for due to past or present service of any Covered Person in the armed forces of a government unless the Covered Person is entitled to elect COBRA Continuation Coverage and/or USERRA continuation coverage and does so when called up to active military duty.

18. Charges incurred for the completion of claim forms (or other forms required by the Plan for the processing of claims) by a Doctor or other provider of services or supplies for which a claim is made.

19. Charges incurred as the result of any injury or sickness for which a Covered Person, whether or not a minor, has the right to recover payment from a third party, except to the extent provided under the Plan's subrogation provisions.

20. Charges incurred for any medical care or any other service or supply for which a Covered Person would not be legally required to pay.

21. Charges incurred for contraceptive devices or any other method of contraception other than covered surgical sterilization or oral birth control medications.

22. Charges incurred for a surgical or other procedure of any type, performed for the purpose of correcting nearsightedness, farsightedness, or astigmatism, including the use of laser technology.

23. Charges for drugs or medications which are not purchased through the Plan's Prescription Drug Program or are obtained in connection with an inpatient or outpatient hospitalization.

The above conditions, limitations and exclusions apply to all benefits provided under the Plan unless an exception is otherwise stated in the Plan. In addition, be sure to read any exclusions and limitations included in the individual benefit explanation sections.

WHERE TO FILE CLAIMS AND HOW TO COLLECT BENEFITS

ALL MEDICAL CLAIMS OTHER THAN MENTAL HEALTH, CHEMICAL DEPENDENCY AND DIAGNOSTIC IMAGING CLAIMS

Send all medical claims for services by PPO and non-PPO providers other than mental health, chemical dependency and diagnostic imaging claims to the PPO Office in the state where the Hospital or Doctor is located.

While many providers will automatically file their claims with the PPO, you are responsible for doing so and if the claim is not filed with the PPO within one year of the date the charges were incurred the claim will not be payable by the Fund.

All claims must indicate the PPO group number. In addition, each claim must clearly identify the Employee's name and identification number, the patient's name and relationship to the Employee, the diagnosis(es), the services provided, the charges incurred and any payments made by the Employee or patient, and the provider's name, address and tax identification number.

MENTAL HEALTH AND CHEMICAL DEPENDENCY CLAIMS

Send all claims for Chemical Dependency and Mental or Nervous Disorders to the Mental Health and Chemical Dependency Review Manager. **No benefits will be payable by the Fund for claims which are not submitted to the Mental Health and Chemical Dependency Review Manager within one year of the date charges were incurred.**

Network Providers - Network providers will submit their claims directly to the Mental Health and Chemical Dependency Review Manager.

Non-Network Providers -You must submit the claim to the Mental Health and Chemical Dependency Review Manager. Each claim must clearly identify the Employee's name and identification number, the patient's name and relationship to the Employee, the diagnosis(es), the services provided, the charges incurred and any payments made by the Employee or patient, and the provider's name, address and tax identification number.

DIAGNOSTIC IMAGING NETWORK CLAIMS

All claims for diagnostic imaging scheduled through the diagnostic imaging network will be sent to the Fund Office by the network. Make sure you show your diagnostic imaging network identification card to the provider before services are rendered. **No benefits will be payable by the Fund for claims which are not submitted to the diagnostic imaging network within one year of the date charges were incurred.**

DENTAL CLAIMS

Send all dental claims to the Fund Office. Each claim must clearly identify the Employee's name and identification number, the patient's name and relationship to the Employee, the diagnosis(es), the services

provided, the charges incurred and any payments made by the Employee or patient, and the provider's name, address and tax identification number. **No benefits will be payable by the Fund for claims which are not submitted to the Fund within one year of the date charges were incurred.**

VISION CLAIMS

Send all non-network vision claims to the vision care network using the claim form available on the vision care network's website. If you do not have access to the Internet, either call the vision network or Fund Office. Network vision claims will be filed with the vision care network by the network provider.

Each claim must clearly identify the Employee's name and identification number, the patient's name and relationship to the Employee, the diagnosis(es), the services provided, the charges incurred and any payments made by the Employee or patient, and the provider's name, address and tax identification number.

No benefits will be payable for claims for which proof of claim is not submitted to the Vision network within one year of the date charges were incurred.

HEARING AID CLAIMS

Send all hearing aid claims to the Fund Office. Each claim must clearly identify the Employee's name and identification number, the patient's name and relationship to the Employee, the diagnosis(es), the services provided, the charges incurred and any payments made by the Employee or patient, and the provider's name, address and tax identification number. **No benefits will be payable by the Fund for claims which are not submitted to the Fund within one year of the date charges were incurred.**

WEEKLY DISABILITY CLAIMS

Send all Weekly Disability Claims to the Fund Office.

1. Contact the Fund Office for a claim form and complete all appropriate questions on the claim form.

2. Have the Doctor who is treating your disability complete and sign his section of the claim form.

3. File Weekly Disability claims immediately, but not later than one year from the onset of the Total Disability otherwise it will not be paid. Do not wait to file a claim until you have returned to work.

LOSS OF LIFE CLAIMS

1. The Fund Office must be supplied with a certified copy of your death certificate, a certified copy of the beneficiary's birth certificate, and a copy of the beneficiary's Social Security card (or other documentation showing the beneficiary's Social Security Number).

2. The Fund Office will issue an IRS Form 1099 for all Loss of Life Benefits paid. If you have questions regarding the tax treatment of Loss of Life Benefits, contact a tax advisor.

3. A certified copy of your death certificate or some other evidence acceptable to the Trustees must be provided to the Fund Office within 12 months of your death. Your beneficiary or beneficiaries

may provide written notice of your death after more than 12 months if it was not reasonably possible to provide proof within 12 months of your death.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) CLAIMS

1. Send the Fund Office documentation of the injury, including medical evidence that you are entitled to Accidental Dismemberment Benefits.

2. If the claim is for an Accidental Death Benefit, the Fund Office must be supplied with a certified copy of the death certificate, a certified copy of the beneficiary's birth certificate, and a copy of the beneficiary's Social Security card (or other documentation showing the beneficiary's Social Security Number).

3. The Fund Office will issue an IRS Form 1099 for all AD&D Benefits paid. If you have questions regarding the tax treatment of AD&D Benefits, contact a tax advisor.

4. A certified copy of your death certificate or other evidence of your loss acceptable to the Trustees must be provided to the Fund Office within 12 months of your death or loss. Your beneficiary may provide written notice of your death after more than 12 months if it was not reasonably possible to provide proof within 12 months of your death.

CLAIM AND APPEAL PROCEDURES

FILING A CLAIM

1. In order for the Plan to pay benefits, a claim must be filed with the Plan, under the procedures described in the *Where to File Claim and How to Collect Benefits* section including the one year limitation on filing claims. A claim can be filed by you, your Dependent, or by someone authorized to act on behalf of you or your Dependent. The Covered Person who has incurred the claim is called the "claimant" except that, if the claim is incurred by a Child, then the adult who files the claim or is legally authorized to act on behalf of the Child is the claimant. In this section, "you" means the claimant.

   For Dental, Hearing, Weekly Disability, Death and ADD, a claim for a benefit is considered to have been filed on the date it is received at the Fund Office. For medical, mental health/chemical dependency, diagnostic imaging and vision, a claim for a benefit is considered to have been filed on the date it is received at the PPO. Even if a claim is incomplete, the claim is considered to have been filed on the date the PPO or Fund Office as applicable first receives notice of the claim.

   If you incur a medical expense and ask the Plan to pay benefits, that is considered a claim. However, a request for confirmation of Plan benefits or eligibility is not a claim if you have not yet incurred the medical expense. The following are examples of situations that do not constitute a claim: an inquiry about general benefit eligibility; a dispute concerning a Plan determination that you or a Dependent is not eligible for benefits, where no medical costs have been incurred; presenting a prescription to a pharmacy, whether or not the pharmacy is a prescription network provider. This paragraph does not apply to "pre-service" claims (defined below).

2. You may designate another person as your authorized representative for purposes of filing a claim. Except in the case of an "urgent care" claim (defined below), such designations must be in writing.

   a. Unless your authorization states otherwise, all notices regarding your claim will be sent to your authorized representative and not to you.

   b. A routine assignment of benefits to a medical provider, so that the Plan will make payment directly to the provider, is not considered to be a designation of the provider as your authorized representative.

TIME PERIODS FOR PROCESSING CLAIMS

The amount of time that the Plan can take to process a health care claim applicable to Comprehensive Medical Expense, Dental, Vision, and Hearing Aid benefits depends on the type of claim. There are three categories:

1. **POST-SERVICE CLAIMS**

   a. A claim is "post-service" if:

      i. The claimant has already received the treatment or service and the claim consists of asking the Plan for payment; or

ii. The treatment or service has not yet been provided but the Plan does not require the claimant to obtain approval before receiving the treatment or service; or

iii. Any other claim that is not a "pre-service" claim or a disability claim (defined below).

b. Approval or denial of a post-service claim will normally be made within 30 days of the date the claim is received by the Plan. If additional time is required, a "Plan extension" will be requested by the Plan.

A "Plan extension" happens when there are circumstances beyond the control of the Plan that cause the Plan to need an extension of time, other than where the claimant has not provided the Plan with all information or documents needed to process the claim. If the Plan needs information or materials from your physician or medical provider, that is not considered a "Plan extension," even though the materials will come from your medical provider and not from you. As a convenience to you, the Plan may request necessary materials or information directly from your medical provider but you are responsible for providing the Plan with that material.

c. In the case of a "Plan extension," the Plan can extend the 30-day claim processing period by 15 days. Before the end of the original 30-day period, you will be notified in writing of the circumstances requiring an extension of time and of the date by which the Plan expects to make a final decision on the claim.

2. **PRE-SERVICE CLAIMS**

a. A claim is "pre-service" only if the Plan specifies that benefits will not be paid unless the claim is approved before care is provided. In addition to normal pre-service claims, there are two special types of pre-service claims, that is, "urgent care" claims and "concurrent care" claims.

URGENT CARE CLAIMS

An urgent care claim is any claim for medical care or treatment with respect to which the application of the periods for making pre-service claim determinations would, in the opinion of a Doctor with knowledge of your condition:

- Seriously jeopardize your life or health or your ability to regain maximum function if normal pre-service standards were applied; or

- Subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought.

CONCURRENT CARE CLAIMS

A concurrent claim is a claim that is reconsidered after it is initially approved and the reconsideration results in:

- Reduced benefits;

- Extension of benefits; or

- A termination of benefits.

b. Approval or denial of a normal pre-service claim (that is, a pre-service claim that is not an "urgent care" or a "concurrent care" claim) will ordinarily be made within 15 days of the date the claim is received by the Plan. If additional time is required, there are two types of extensions that may apply: a "claimant extension" or a "Plan extension."

- A "claimant extension" occurs when the Plan needs additional material or information from you or your medical provider. When there is a "claimant extension," the Plan will request the necessary information or material in writing. If the request goes to your medical provider, you will receive a copy of the request. You will then have 45 days to submit, or have your medical provider submit, the information the Plan needs to process your claim. When a "claimant extension" is in effect, the time for the Plan to decide your claim is extended by the time it takes you to provide the requested information. Once the Plan has received a response to its request, the ordinary time limits (the 30-day period or the 15-day extension) will again start to run. If you do not respond to the Plan's request within 45 days, the Plan will decide your claim without that information.

- If a "Plan extension" is necessary, the Plan can extend the 15-day time period by another 15 days. Before the end of the original 15-day period, you will be notified in writing of the circumstances requiring a "Plan extension" and the date by which the Plan expects to make a final decision on the claim.

c. The Trustees expect that there will be few, if any, "urgent care" claims because there are few circumstances in which the Plan conditions eligibility for a benefit on prior approval of the treatment. However, if such a situation arises, the following time limits apply.

- Within 72 hours of the Plan's receipt of an "urgent care" claim, the Plan (or its representative) will advise you whether or not the treatment or service is approved. This notice may be given by telephone or in writing, but if the notice is by telephone, a written confirmation will follow within 3 days. If the Plan cannot process the claim without additional material or information from you or your medical provider, that will cause a "claimant extension" and the Plan will request the necessary material within 24 hours of receipt of the claim. You will be given no less than 48 hours to provide the needed information. Once the Plan has received a response to its request, the Plan will make a determination on your claim within 48 hours of the time the additional information is received or, if no information is provided, within 48 hours of the expiration of the time period within which a response was to be made, whichever is earlier.

- For "urgent care" claims, a medical professional with knowledge of your medical condition can act as your authorized representative. The Plan will not require the medical professional to show that you have designated him/her as your authorized representative.

d. Concurrent care claims are processed within the same time limits that apply to normal pre-service claims unless the "concurrent care" claim is also an "urgent care" claim. The following additional rules apply to "concurrent care" claims.

- If the Plan has approved coverage for a specified period of treatment and you request an extension of that period, the request for an extension is treated as a new pre-service claim. However, if the extension request is an "urgent care" claim, the Plan will notify you of its decision within 24 hours of the Plan's receipt of the request, provided that the request for an extension is received more than 24 hours before the end of the originally approved period of treatment. Otherwise, the time periods for processing an "urgent care" claim will apply.

- If you have a "concurrent care" claim and the Plan terminates or reduces a previously approved period of treatment, you will have the right to appeal that termination or reduction.

(The rules governing appeals are explained below.) The Plan will give you 10 days' advance notice of such a termination or reduction. If you appeal the termination or reduction within the 10-day period, the Plan will not implement the termination or reduction before you are given notice of the outcome of the appeal. This rule, allowing the course of treatment to continue pending an appeal, does not apply if your benefits terminate because you have lost eligibility under the Plan or if the termination or reduction of benefits is the result of a Plan amendment.

3. **DISABILITY CLAIMS**

a. Claims for Weekly Disability Benefits are disability claims. If there is any other Plan benefit that is conditioned on a finding of disability then that is also a disability claim.

b. Approval or denial of a disability claim will normally be made within 45 days of the date the claim is received by the Plan.

- If a "Plan extension" is necessary, the Plan can extend the 45-day time period by 30 days. If the 30-day extension is not sufficient, the Plan can apply a second 30-day extension. Before the end of the original 45-day period (or, for a second extension, before the end of the first 30-day extension), you will be notified in writing of the circumstances requiring an extension of time and of the date by which the Plan expects to make a final decision on the claim.

- When the Plan needs additional material or information from you or your medical provider, that is a "claimant extension." When there is a "claimant extension," the Plan will request the necessary information or material in writing. If the request goes to your medical provider, you will receive a copy of the request. You will then have 45 days to submit, or have your medical provider submit, the information the Plan needs to process your claim. When a "claimant extension" is in effect, the time for the Plan to decide your claim is extended by the time it takes you to provide the requested information. Once the Plan has received a response to its request, the ordinary time limits (the 30-day period or the 15-day extension) will again start to run. If you do not respond to the Plan's request within 45 days, the Plan will decide your claim without that information, which may result in the denial of your claim.

4. **LOSS OF LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT DETERMINATION PROCEDURESISABILITY CLAIMS**

You will receive a decision on your Loss of Life or AD&D claim within 90 days of the date the Plan receives your claim. The Loss of Life Benefit will be paid in full, in accordance with the terms of the Loss of Life Benefit or Accidental Death and Dismemberment Benefit provisions of the Plan and Schedules of Benefits, after the Fund Office receives a certified copy of a the death certificate or other relevant proof of loss.

DENIAL OF CLAIMS

DENIAL OF CLAIMS

If your claim is denied in whole or in part, the Plan will send you a written notice stating the specific reason or reasons for the denial, making reference to pertinent Plan provisions on which the denial was based. A notice of claim denial will also include:

1. a summary of the Plan's appeal procedures;

2. if applicable, a description of any additional material or information necessary to process your claim, along with an explanation of why such material or information is necessary;

3. if applicable, a statement that, upon written request, you will be furnished with a copy of any internal rule, guideline or policy that the Plan relied on in processing your claim;

4. if applicable, a statement that, upon written request, you will be furnished with an explanation of any scientific or clinical judgment used by the Plan in denying your claim if the Plan found that the treatment was Experimental or Investigational or not Medically Necessary; and

5. a statement that Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA,") provides that a participant or beneficiary of an employee benefit plan may file suit to recover benefits due under the terms of the Plan, to enforce the terms of the Plan or to clarify the person's right to future benefits under the Plan.

APPEALING THE DENIAL OF A CLAIM

If your claim has been denied in whole or in part, you may request a full and fair review (referred to in these Procedures as an "appeal") by filing a written notice of appeal with the Plan.

1. A notice of appeal must be received at the offices of the Fund Office not more than 180 days after receipt by the claimant of the written notice of denial of a claim. Your appeal is considered to have been filed on the date the written notice of appeal is received at the Fund Office.

2. If you wish, another person may represent you in connection with an appeal. If another person claims to be representing you in your appeal, the Trustees have the right to require that you give the Plan a signed statement, advising the Trustees that you have authorized that person to act on your behalf regarding your appeal. Any representation by another person will be at your own expense.

3. In connection with your appeal, you or your authorized representative may review pertinent documents and may submit issues and comments in writing.

    a. Upon written request, the Plan will provide reasonable access to, and copies of, all documents, records or other information relevant to your claim.

    b. If the Plan obtained an opinion from a medical or vocational expert in connection with your claim, the Plan will, on written request, provide you with the name of that expert.

    c. The Plan will not charge you for copies of documents you request in connection with an appeal.

4. Appeals of post-service claims and disability claims will be decided by the Review Committee of the Board of Trustees. Review Committee meetings shall be conducted according to rules of uniform application adopted by the Board of Trustees from time to time and at any time, for example no audio or visual recordings of any type including transcription by court reporters are permitted. You (and your authorized representative, if any) may appear before the Review Committee, if you so request in writing and a hearing will be held on the appeal.

5. In deciding your appeal, the Review Committee will consider all written comments and documents that you submit, regardless of whether that information was available at the time of the original claim denial.

a. In deciding your appeal, the Review Committee will not presume that the original denial was correct and will consider the issues with no deference to the original decision.

b. If an appeal involves a medical judgment, such as whether treatment is Medically Necessary, the Review Committee will consult with a medical professional who is qualified to render an opinion on the issue. If a medical professional was consulted in connection with the original claim denial, the Review Committee will not consult with the same medical professional (or a subordinate of that person) for purposes of the appeal.

6. An expedited appeals process exists for urgent care claims. Under this process, you can request an appeal of an adverse benefit determination orally or in writing, and all necessary information, including the Fund's determination on appeal, will be transmitted to you by telephone, fax or other available similarly expeditious method.

TIME PERIOD FOR PROCESSING APPEALS

POST-SERVICE CLAIMS AND DISABILITY, LOSS OF LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT CLAIMS – The Review Committee meets 6 times per year.

1. If your appeal is filed more than 30 days prior to a regular meeting of the Review Committee, your appeal will be decided at that meeting unless special circumstances require an extension of time for processing, in which case a decision will be made on your appeal at the next following Review Committee meeting.

   Whenever there are "special circumstances" that require that the decision be delayed until the next following Review Committee meeting, you will be advised in writing of why the extension of time was needed and when the appeal will be decided.

2. If your appeal is filed within the 30-day period immediately preceding the regular meeting of the Review Committee, the appeal will not be decided at that meeting but will be decided at the next following Review Committee meeting, unless special circumstances require an extension of time for processing. In that case, a decision will be made on your appeal at the third Review Committee meeting following the date your appeal was filed.

   Whenever there are "special circumstances" that require that the decision be delayed until the next following Review Committee meeting, you will be advised in writing of why the extension of time was needed and when the appeal will be decided.

3. When the Review Committee determines, in its sole discretion, that it can decide an appeal sooner than the time limits stated above, the Review Committee will do so.

4. The Plan will mail you a written notice of a Review Committee's decision within 5 days after the decision has been made.

PRE-SERVICE

1. For a pre-service claim that is not an "urgent care" claim, the Plan will notify you of the decision on appeal within 30 days of the Plan's receipt of the appeal.

2. For an "urgent care" claim, the Plan will notify you of the decision on appeal within 72 hours of the Plan's receipt of the appeal. Also, for appeals of "urgent care" claims, the notice of appeal can be oral instead of in writing, and the Plan may notify you of its decision by telephone or facsimile ("fax".)

3. If a claimant whose pre-service claim was denied obtains the service or treatment that had been denied, the claim is no longer a pre-service claim and any appeal of the denial of the pre-service claim will be handled under the rules that apply to post-service claims.

DECISIONS ON APPEAL

1. Notice will be given that the Review Committee has decided your appeal and will state the specific reason or reasons for the decision, making reference to pertinent Plan provisions on which the decision was based. If applicable, the notice will also include:

   a. A statement that, upon written request, you will be furnished with a copy of any internal rule, guideline or policy that the Plan relied on in processing your claim; and

   b. A statement that, upon written request, you will be furnished with an explanation of any scientific or clinical judgment used by the Plan in denying your claim if the Plan found that the treatment was Experimental or Investigational or not Medically Necessary.

2. If your appeal is denied, you are entitled to receive, upon written request and at no cost, copies of documents and information that the Plan relied on in denying your claim.

3. If the Review Committee upholds the denial of your claim, you will then have the right to file suit, under the authority of Employee Retirement Income Security Act of 1974, as amended ("ERISA".)

4. If the decision on a claim or the decision on appeal is not furnished within the time limits stated in these Procedures, the claim or appeal is deemed to have been denied. No claim shall be considered to have been denied, and a claimant may not file suit against the Plan, until the claimant has exhausted all of the procedures described in these Claim and Appeal Procedures.

LEGAL PROCEEDINGS

You may not bring any action in court to recover Plan benefits:

- before you have exhausted all of your remedies under the Plan's Claim and Appeal Procedures; and

- after two years from the expiration of the time allowance within which you were required to file an appeal with the Plan.

ASSIGNMENT OF BENEFITS

You may not anticipate, alienate, sell, transfer, pledge, assign, or otherwise encumber any interest in benefits to which you are or may become entitled under the Plan. The Trustees may, however, honor your assignment of benefits to the provider of covered services.

Neither you nor your beneficiary may transfer or assign any Loss of Life and AD&D Benefit payments in anticipation of receiving them.

BENEFIT PAYMENT TO AN INCOMPETENT PERSON

Benefit payments under the Plan may become payable to a person who is adjudicated incompetent. In this event, the Trustees may make such payments for the benefit of the incompetent person as they deem best.

The Trustees will have no duty or obligation to see that the funds are used or applied for the purpose or purposes for which paid if they are paid:

- directly to the person;
- to the legally appointed guardian or conservator of such person;
- to any Spouse, child, parent, brother, or sister of such person for the welfare, support, and maintenance of the person; or
- by the Trustees directly for the support, maintenance and welfare of the person.

If any question or dispute arises concerning the proper person or persons to whom any payment will be made under the Plan, the Trustees may withhold payment until a binding adjudication of the question or dispute is made. The resolution must be satisfactory to the Trustees in their sole discretion. Alternatively, the Trustees may pay the benefits if they have been adequately indemnified to their satisfaction against any resulting loss.

DEFINITIONS

CALENDAR YEAR – The twelve month period beginning on January 1 and ending on the next following December 31.

CHEMICAL DEPENDENCY – A condition characterized by an overwhelming and/or uncontrollable desire or need (compulsion) to continue use of an addictive drug or chemical substance, including alcohol, and to obtain it by any means, with a tendency to increase the dosage, with resultant physiological and/or psychological dependence on its effects and a detrimental effect on the individual and on society.

CHIROPRACTIC – For the purpose of the Plan, Chiropractic means the treatment of disease or injury, by a health care provider, by manipulation and adjustment of any skeletal or other body structure.

COLLECTIVE BARGAINING AGREEMENT(S) – Any collectively bargained agreement in effect between the Union and an Employer that requires the Employer to make Contributions to the Fund on behalf of its Employees.

CONTRIBUTIONS – Payments made to the Fund by Employers on behalf of their Employees for work performed by the Employees pursuant to the terms of a Collective Bargaining Agreement or a Participation Agreement.

CONTRIBUTION PERIOD – The twelve month period beginning October 1 and ending on the next following September 30.

CONVENIENT CARE CLINICS (CCC) – Health care clinics located in retail stores, supermarkets and pharmacies that treat uncomplicated minor illnesses and provide preventive health care services. They are also referred to as "walk-in medical clinics", "retail based clinics" or "mini-clinics."

COVERED EMPLOYMENT – An Employee's employment with an Employer who is obligated to make Contributions to the Fund on the Employee's behalf under the terms of a Collective Bargaining Agreement or Participation Agreement.

COVERED EXPENSES – Expenses that are covered under the Plan or under any applicable benefit provision of the Plan (for example, the Comprehensive Medical Expense Benefit, the Dental Expense Benefit, etc.), subject to all applicable limitations and exclusions governing such expenses.

COVERED PERSON – An Eligible Employee, Eligible Retiree or Dependent.

DENTIST – A person who is licensed to practice dentistry or oral surgery in the jurisdiction in which the services were performed.

DEPENDENT – (For the purposes of this definition, the term "you" or "your" applies to an Eligible Employee or an Eligible Retiree.)

A Dependent is a person who has been enrolled in the Plan and who is:

1. The Spouse of an Eligible Employee or Eligible Retiree (See Definition of Spouse). Your Spouse is not considered a Dependent if he or she is a full-time active member of the armed forces of any country.

Definition of Spouse A Spouse is a person to whom an Eligible Employee (or Eligible Retiree) is legally married, including individuals married to a person of the same sex who were legally married in a state that recognizes such marriages but who are domiciled in a state that does not recognize such marriages.

2. Your Child (see Definition of Child) who is:

   a. less than age 26 whether unmarried or married; or

   b. age 26 or older whether unmarried or married and:

      i. who is not covered under Medicare; and

      ii. who meets the definition of a Child except for age; and

      iii. who is permanently and totally disabled, which means that the Child is unable to engage in any gainful activity by reason of a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of twelve months or more; and

      iv. who is dependent on the Eligible Employee (or Eligible Retiree) for more than 50% of his support and maintenance for the Calendar Year and resides with the Eligible Employee (or Eligible Retiree) for more than one-half of the Calendar Year; and

      v. who became so disabled before he or she reached age 26.

      If a Child meets all of these conditions, he or she will be covered under the Plan as long as the Eligible Employee (or Eligible Retiree) stays eligible and as long as the Child remains disabled and unable to support himself or herself. If requested by the Trustees, the Eligible Employee (or Eligible Retiree) must provide proof of the Child's disability and that he or she became disabled before he became age 26. If requested by the Trustees, the Eligible Employee (or Eligible Retiree) must provide proof of the Child's continued disability each Calendar Year. It is the responsibility of the Eligible Employee (or Eligible Retiree) to provide all proof of disability at his or her own expense. If the Eligible Employee (or Eligible Retiree) fails to provide the proof when required, the Child's eligibility will terminate.

Definition of Child – A Child means any of the following:

1. The natural child of an Eligible Employee (or Eligible Retiree).

2. Any child legally adopted by an Eligible Employee (or Eligible Retiree) or placed in the home of an Eligible Employee (or Eligible Retiree) for adoption.

3. Any stepchild of the Eligible Employee (or Eligible Retiree) (meaning any child of the Eligible Employee's (or Eligible Retiree's) Spouse who was born to the Spouse or who was legally adopted by or placed for adoption with the Spouse before marriage to the Eligible Employee (or Eligible Retiree).

4. Any child named as an "alternate recipient" under the terms of a medical child support order that is determined to be a Qualified Medical Child Support Order. The Eligible Employee (or Eligible Retiree) must submit a copy of any such medical child support order to the Fund Office before

claims for the child will be considered for payment. The Eligible Employee (or Eligible Retiree) can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations by calling or writing the Fund Office.

5. Any other child for whom the Eligible Employee (or Eligible Retiree) is legally responsible to provide medical care, provided that:

   a. the child's parents are deceased or the child has been legally removed from the parents' custody and legally placed in the Eligible Employee's (or Eligible Retiree's) permanent custody; and

   b. no state or private social service agency pays any support or compensation to the Eligible Employee (or Eligible Retiree) or any member of the Eligible Employee's (or Eligible Retiree's) household for the support or maintenance of the child;

   c. the child resides with the Eligible Employee (or Eligible Retiree) for the entire Calendar Year, is a member of the Eligible Employee's (or Eligible Retiree's) household for the entire Calendar Year, and is not a dependent of any other person for the Calendar Year.

A Child is not a Dependent if he or she is a full-time active member of the military service or armed forces of any country or nation or if he or she is an Eligible Employee. However, a Child under age 26 who is an Employee of a Contributing Employer will be a Dependent until the earlier of the effective date of Employee coverage under the Plan or until he or she reaches age 26.

Only a Spouse or Child who meets the Plan's definition of a Dependent is eligible for coverage under the Plan.

DOCTOR - A person who is licensed under the Illinois Medical Practice Act or licensed under a comparable statute in another jurisdiction within the U.S., its territories and protectorates to give medical care or treatment for the type of illness or injury for which a claim is made and who is acting within the scope of that license.

ELIGIBLE EMPLOYEE – Any Employee who has met the applicable eligibility requirements for being eligible to receive Plan benefits for Employees.

ELIGIBLE RETIREE – A Retired Employee who is under age 65 and eligible to receive early, normal or disability benefits under the Roofers' Pension Fund.

EMERGENCY ADMISSION – An admission as an inpatient to a Hospital for the sudden and acute onset of an injury, ailment, condition, disease, disorder, or illness manifesting itself by severe acute symptoms. The condition must be one that, in the absence of immediate and ongoing medical attention as an inpatient, would reasonably result in permanently placing the Covered Person's health in jeopardy, serious impairment to bodily functions, serious and permanent dysfunction of any body organ or part, or other serious medical consequences.

EMPLOYEE – You meet the definition of an Employee if you are:

1. employed by an Employer who makes Contributions to the Fund for you under the terms of a Collective Bargaining Agreement with the Union;

2. employed by the Union or the Chicagoland Roofers' Joint Apprenticeship and Training Fund as a full-time employee regularly scheduled to work 30 or more hours per week;

3. not a member of a collective bargaining unit represented by the Union, and Contributions are made to the Fund on your behalf under the terms of a Participation Agreement; and

4. employed by the Fund as a full-time employee regularly scheduled to work 30 or more hours per week.

EMPLOYER; CONTRIBUTING EMPLOYER – An Employer is:

1. any person, firm, association, partnership or corporation that enters into a Collective Bargaining Agreement with the Union that requires Contributions to be made to the Fund for the Employer's Employees; and

2. the Union or the Chicagoland Roofers' Joint Apprenticeship and Training Fund, which is required under the terms of the Trust Agreement to make Contributions to the Fund on behalf of its full-time office staff Employees who are regularly scheduled to work 30 or more hours per week and who are not covered by a Collective Bargaining Agreement; and

3. the Fund.

EXPERIMENTAL OR INVESTIGATIVE – A treatment, procedure, facility, equipment, drug, device or supply will be considered to be Experimental or Investigative if it falls within any one of the following categories:

1. It is not yet generally accepted among experts as accepted medical practice for the patient's medical condition; or

2. It cannot be lawfully marketed or furnished without the approval of the U.S. Food and Drug Administration or other Federal agency, and such approval has not been granted at the time the treatment, procedure, facility, equipment, drug, device or supply was rendered, provided or utilized; or

3. It is the subject of ongoing Phase I or Phase II clinical trials, or is the research, experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses, or if the prevailing opinion among experts regarding any such treatment, procedure, facility, equipment, drug, device or supply is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses.

Whether a treatment, procedure, facility, equipment, drug, device or supply is Experimental or Investigative will be determined solely by the Trustees, in their sole and unrestricted discretion and judgment in accordance with the foregoing definition.

FUND; TRUST FUND; WELFARE TRUST FUND – The Roofers' Unions Welfare Trust Fund, as created and existing under the Trust Agreement.

HOME HEALTH AGENCY – A public agency or private organization that is primarily engaged in providing skilled nursing services and other therapeutic services in the homes of its patients, and that meets the following requirements:

1. It has policies, established by a group of professional personnel associated with the agency or organization, governing the services it provides; and

2. It provides for the supervision of its services by a Doctor or R.N. and maintains clerical records on all its patients; and

3. It is licensed according to the applicable laws of the state in which the person receiving the treatment lives and of the locality in which it is located or provides services; and

4. It is eligible to participate in Medicare.

HOSPICE – A public agency or private organization, or a part of either, that is primarily engaged in providing a coordinated set of specified services at home, in outpatient settings, or in institutional settings for individuals suffering from conditions that have a terminal prognosis. An agency or an organization must meet all of the following criteria in order to be considered an approved Hospice for the purposes of the Plan:

1. It must be eligible to participate under the provisions of Medicare;

2. It must have an interdisciplinary group of personnel that includes at least one Doctor and one R.N.;

3. It must maintain central clinical records on all patients;

4. It must meet the standards of the National Hospice and Palliative Care Organization (NHPCO); and

5. It must provide either directly, or under other arrangements, the following core services when required:

    a. Nursing care by an R.N. or L.P.N. and services of homemakers and home health aides;

    b. Medical social services;

    c. Counseling services and/or psychological therapy by a social worker or a psychologist;

    d. Chaplaincy;

    e. Physical and occupational therapy;

    f. Speech language pathology;

    g. Non-prescription drugs utilized for palliative care;

    h. Medical supplies, bandages and equipment, and drugs and biologicals used for pain and symptom control; and

    i. Skilled nursing facility short-term inpatient care to provide respite care, palliative care or care in periods of crisis.

HOSPITAL – An institution that is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patient's expense, and that meets the following requirements:

1. It is a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or

2. It is a hospital or a psychiatric hospital, as defined in Medicare, which is eligible to participate in and to receive payments in accordance with the provisions of Medicare.

3. The term "Hospital" does not include a convalescent nursing home, an institution or part of an institution that:

   a. is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged;

   b. furnishes primarily domiciliary or custodial care, including training in the routines of daily living;

   c. is operated primarily as a school; or

   d. is a Hospice.

ILLINOIS VALLEY AREA – The geographic area of the Illinois counties of Bureau, Grundy, LaSalle and Putnam.

L.P.N. – Licensed practical nurse.

MEDICAL EMERGENCY – The sudden and unexpected onset of an illness or injury. Medical emergencies include, but are not limited to, heart attacks, strokes, loss of consciousness or respiration, convulsions, and other acute conditions. A condition will be a Medical Emergency only if severe symptoms occur suddenly and unexpectedly, or the illness or injury, as finally diagnosed, required immediate medical care at the nearest Hospital qualified to provide treatment.

MEDICAL REVIEW MANAGER – An organization with which the Trustees have a contract to provide utilization review and certification services.

MEDICALLY NECESSARY – Only those services, treatments or supplies provided by a Hospital, a Doctor or other covered provider that are required, in the judgment of the Trustees based on the opinion of a medical professional who is qualified to render an opinion on the issue, to identify or treat an injury or sickness and which are consistent with the symptoms or diagnosis and treatment of the patient's condition, sickness, injury, disease, or ailment; and appropriate according to standards of good medical practice; not solely for the convenience of the patient, the Doctor, the Hospital or the other covered provider; and not Experimental or Investigative.

MENTAL HEALTH AND CHEMICAL DEPENDENCY REVIEW MANAGER – A mental health management organization with which the Trustees have a contract to provide certain services related to the care and treatment of Chemical Dependency, Mental or Nervous Disorders and other life problems. These services include an employee assistance program, utilization review, certification services, and a Mental Health provider network.

MENTAL OR NERVOUS DISORDER – An emotional disease, including a neurosis, psychoneurosis, psychopathy or psychosis, regardless of whether such disease has causes or origins that are organic, physiological, traumatic, or functional.

NON-BARGAINING UNIT EMPLOYEES – Employees of the Union, the Chicagoland Roofers' Joint Apprenticeship and Training Fund and the Fund Office.

NURSE PRACTITIONER – Licensed registered nurses with advanced education and training who perform tasks often performed by Doctors. They must work under the direction, supervision and responsibility of a Doctor and provide a broad scope of health care services, such as taking medical

histories, examining patients, assisting with care management, coordinating care, ordering and analyzing laboratory tests and x-rays and making diagnoses.

NURSE SURGICAL ASSISTANT – A person who is either an RN, Physician Assistant, or other individual who is trained and specializes in surgical assistance. Nurse Surgical Assistants must complete a course of training, which includes classroom instruction, clinical instruction, and clinical application. Nurse Surgical Assistants are required to practice under the direct supervision of the Doctor who is a surgeon and the surgeon must be physically present when the Nurse Surgical Assistant is practicing.

OCCUPATIONAL THERAPY – Therapeutic use of work, self-care and play activities to increase independent function, enhance development and prevent disability; it may include adaptation of a task or environment to achieve maximum independence and to enhance the quality of the patient's life.

OUTPATIENT SURGICAL FACILITY – A health care facility that is operated for the primary purpose of performing surgery on an outpatient basis and to which a patient is usually admitted to and discharged from within 24 hours, and that meets the following requirements:

1. It is regularly licensed as an outpatient surgical facility (by whatever name called) by the governmental or other agency that has the responsibility for such licensing; and

2. It is supervised by a full-time Doctor and keeps medical records on all patients; and

3. Every Doctor performing surgery on the premises is also allowed to perform surgery in a local Hospital; and

4. It employs or has available a licensed anesthesiologist and an R.N.; and

5. It has at least two operating rooms and a recovery room, is equipped to take care of emergencies, and has an agreement with a local Hospital to take patients who develop problems.

An office maintained by a Doctor for the practice of medicine, an office maintained by a Dentist for the practice of dentistry, or a facility primarily engaged in the termination of pregnancy is not considered an Outpatient Surgical Facility.

OWNER – An individual who has any ownership interest in a Roofing Contractor, whether as a sole proprietor, partner, shareholder or otherwise, that is signatory to a Collective Bargaining Agreement.

OWNER PARTICIPANT – An Owner or the Spouse of an Owner who performs work under the jurisdiction of the Collective Bargaining Agreement.

PARTICIPATION AGREEMENT – An agreement between the Trustees and an employer under which the employer agrees to make Contributions to the Fund on behalf of the employer's Employees who are not covered under a Collective Bargaining Agreement.

PENSION-VESTED – An Employee or Retiree is Pension -Vested if he or she has earned the number of years of vesting service necessary to be eligible to receive a pension from the Roofers' Pension Plan.

PHYSICAL THERAPY – Therapeutic exercises, rehabilitative programs and physical agents, such as massage, heat, hydrotherapy and electricity, for the treatment of persons disabled by pain, disease or injury.

PHYSICIAN ASSISTANTS – Health care professionals licensed to practice medicine in medical and surgical settings under the supervision of a Doctor.

PLAN; PLAN OF BENEFITS; PLANS II, II-PA and III – The Roofers' Unions Welfare Trust Fund Plan or the overall benefit program and the scheduled programs of benefits for which an Employee, Retiree or Dependent is or may become eligible for as set forth in the Plan, established by, and as it may from time to time be amended by the Board of Trustees pursuant to the provisions of the Trust Agreement.

PREFERRED PROVIDER ORGANIZATION (PPO) – An organization with which the Trustees have a contract to make the services of networks of Hospitals and/or Doctors and other facilities available to Covered Persons at negotiated rates to the Fund. "PPO Hospitals" are Hospitals that are in the PPO Network." "PPO Doctors" are Doctors that are in the PPO Network. "PPO providers" is a term used to mean both PPO Hospitals and PPO Doctors and other PPO facilities.

REASONABLE AND CUSTOMARY; REASONABLE AND CUSTOMARY CHARGE –The maximum allowable charge to be considered a Covered Expense under the Plan. For network providers, the Reasonable and Customary charge means the contracted rate set forth in the contract between the Preferred Provider Organization (PPO) and its preferred providers. With respect to non-network providers, the amount of a Reasonable and Customary Charge will be based on 100% of the Medicare approved amount (also referred to as the Medicare reimbursement rate.) If a particular charge is more than the amount considered to be a Reasonable and Customary Charge, any amount over the Reasonable and Customary Charge will not be recognized by the Plan as a Covered Expense.

RETIREE – A retired Employee.

RETIRE OR RETIREMENT – Termination of covered or industry employment after fulfillment of all age and service requirements for a normal, early or disability pension from the Roofers' Pension Plan and written application for pension benefits has been made.

R.N. – A Registered Nurse.

ROOFERS' INTERNATIONAL UNION – The United Union of Roofers, Waterproofers and Allied Workers.

ROOFERS' PENSION PLAN – The retirement plan maintained by the Roofers' Pension Fund, the employee pension benefit plan established by the Union and Employers with which the Union bargains collectively.

ROOFING CONTRACTOR – Any entity, whether a sole proprietor, partner, shareholder or a member of a Limited Liability Company or similar form of business, which is signatory to a Collective Bargaining Agreement.

SELF-PAYMENTS – Payments made to the Fund by Eligible Employees, Eligible Retirees and Dependents for the purpose of maintaining eligibility for Plan benefits in accordance with applicable Plan provisions governing eligibility.

SHIFT – A consecutive-hour working period.

SKILLED NURSING FACILITY – A facility that meets all the following requirements:

1. It complies with all licensing and other legal requirements; and

2. It is primarily engaged in providing inpatient skilled nursing care, physical restoration services, and related services for persons who are convalescing from injuries and/or sicknesses and who require medical or nursing care to assist them in reaching a degree of body functioning to permit self-care in essential daily living activities; and

3. It provides 24-hour-a-day supervision by one or more Doctors and one or more R.N.s responsible for the care of its inpatients, 24-hour-a-day nursing services by licensed nurses under the supervision of an R.N., and has an R.N. on duty at least eight hours a day; and

4. Every patient is under the supervision of a Doctor and it has available at all times the services of a Doctor who is a staff member of a general Hospital; and

5. It maintains daily medical records on all patients, has appropriate methods and procedures for the dispensing and administering of drugs and biologicals, has in effect a utilization review plan, and has in effect a transfer agreement with one or more Hospitals; and

6. It is eligible to participate under Medicare; and

7. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and

8. It is not, other than incidentally, an institution that is a place for rest, for custodial care, for the aged, for drug addicts, for alcoholics, a hotel, a place for the care and treatment of mental diseases or tuberculosis, or any similar institution.

TOTALLY DISABLED; PERMANENTLY AND TOTALLY DISABLED

1. With respect to receiving Weekly Disability Benefits, an Eligible Employee is considered to be Totally Disabled if he or she is totally prevented from performing each and every duty of his or her normal occupation or employment as a result of a non-occupational accidental injury or sickness and is not performing or engaging in any occupation or employment for wage, remuneration or profit.

2. With respect to receiving disability hours in accordance with the Plan's eligibility rules, an Eligible Employee is considered to be Totally Disabled if he or she is totally prevented from performing each and every duty of his or her normal occupation or employment as a result of an occupational or non-occupational accidental injury or sickness and is not performing or engaging in any occupation or employment for wage, remuneration, or profit.

3. With respect to the "Continuation of the Loss of Life Benefit During Permanent and Total Disability," and for continuation of Plan coverage after an Eligible Employee has used up his or her credited disability hours, an Eligible Employee is considered to be Permanently and Totally Disabled if he or she is completely and totally prevented from performing any work or from engaging in any type of gainful occupation or employment for compensation, remuneration, wage, or profit as a result of an occupational or non-occupational accidental injury or sickness.

TRUST AGREEMENT – The amended Agreement and Declaration of Trust, including all amendments, establishing the Trust Fund and its rules of operation.

TRUSTEES – The members of the Board of Trustees designated pursuant to the Trust Agreement.

UNION – The United Union of Roofers, Waterproofers and Allied Workers, Local No. 11, AFL-CIO.

GENERAL PLAN PROVISIONS

GENERAL PLAN PROVISIONS

CIRCUMSTANCES UNDER WHICH COVERAGE MAY BE REDUCED

Notwithstanding any provision contained in the Plan to the contrary, in the event the Covered Person is also covered under another group health plan (the "other plan"), and the other plan reduces its coverage in any respect because the Covered Person is also covered under the Plan (the "reduced coverage"), then in any event, the amount payable under the Plan shall be the lesser of the coverage otherwise payable under the Plan or the reduced coverage payable under the other plan.

COORDINATION OF BENEFITS (C.O.B.)

Benefits are coordinated when both you and your Spouse (and/or your Children) are covered by this Plan as well as by another group health plan (usually your Spouse's plan.) Coordination allows benefits to be paid by two or more plans, up to but not to exceed 100% of the allowable expenses of the claim.

GENERAL C.O.B. INFORMATION

1. Benefits are coordinated on all Employee, Retiree, and Dependent claims under this Plan. C.O.B. applies only to medical, dental, orthodontia, periodontal and vision care benefits; it does not apply to Loss of Life Benefits, AD&D Benefits, Weekly Disability Benefits or benefits under the Prescription Drug Program.

2. You must file a claim for any benefits you are entitled to from any other source. Whether or not you file a claim with these other sources, your Plan benefits will be calculated taking into account any benefits you are entitled to receive from the other source(s).

3. The Fund Office may exchange any necessary information about your claim with other sources. You must furnish the Fund Office with any information they need to process your claim.

4. Benefits are paid for "allowable expenses," which are expenses that are eligible to be considered for reimbursement under at least one of the plans.

5. Benefits are coordinated with other group plans, including group Blue Cross and Blue Shield, Medicare, school, motor vehicle and excess insurance plans. If you or your Spouse are covered under another plan, you can contact the Fund Office to find out whether that plan fits the definition of a group plan.

6. A "primary" plan is the plan that is required to pay its benefits before another plan pays its benefits; a "secondary" plan is the plan that pays its benefits after the other plan has paid its benefits.

ORDER OF BENEFIT PAYMENTS WHEN TWO OR MORE PLANS ARE INVOLVED

1. If you and your Spouse are both covered as Employees or Retirees under this Plan, benefits on claims for either of you will be payable only as the claim of an Employee or a Retiree.

2. If the other Plan does not have C.O.B. rules, that Plan is primary and this Plan is secondary.

3. When the other Plan has C.O.B. rules, the plan covering the Covered Person for whom the claim is filed as an Employee is primary, and the plan covering the person for whom the claim is filed as a Dependent or as an inactive or retired Employee is secondary. The plan covering the person as a Dependent of an active Employee is primary and the plan covering the Covered Person as a Dependent of an inactive or retired Employee is secondary.

4. On claims for Children:

   a. If the parents are married or living together, and if there is no controlling court order, the plan covering the parent whose birthday comes first in the year, is primary and the plan covering the parent whose birthday comes later in the year is secondary.

   b. When the parents are divorced, or were never married and are not living together, benefits are payable according to any existing court decree that establishes which parent has financial responsibility for the Child's health care. If there is not a court decree stating who is responsible for a Child's health care, the plan covering the parent with custody (if not remarried) is primary and the plan covering the parent without custody is secondary. If the parent with custody has remarried, the custodial parent's plan is primary, the stepparent's plan is secondary, and the non-custodial parent's plan pays after that.

   c. If you and your Spouse are both covered as Employees or Retirees under the Plan, all benefits for a Child of yours will be paid only as though the Child is the Dependent of one of you.

   d. If a Child is covered under this Plan as an Employee, this Plan will not coordinate with itself on a claim submitted by or on behalf of the Child and will pay the claim only as a claim of an Employee.

5. Unless Item 6 below applies, if a Covered Person is covered under another group health plan and also has COBRA Continuation Coverage and/or USERRA continuation coverage under the Plan, the Plan's COBRA Continuation Coverage and/or USERRA continuation coverage will be secondary to the non-COBRA plan. 6. If the above rules still do not clearly show which plan is primary, the plan that has covered the person for the longest continuous period of time is primary, the plan that has covered the person for the next longest continuous period of time is secondary.

6. Regardless of the above rules, if another Plan refuses to coordinate benefits with this Plan on a basis commonly accepted by insurance companies doing business in the state of Illinois, or if that other Plan provides that it will only be secondary to this Plan, then the benefits payable under this Plan will be limited to 50% of the Reasonable and Customary charge.

RIGHT TO RECEIVE AND RELEASE INFORMATION

For the purpose of administering the coordination of benefits provisions of this Plan or of any other plan, the Trustees may, without consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Trustees deem to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Trustees such information that may be necessary to administer the coordination of benefits provisions of this Plan.

FACILITY OF BENEFIT PAYMENT

Whenever payment which should have been made under this Plan pursuant to its coordination of benefits provisions have been made under any other plans, the Trustees shall have the right, in their sole

discretion, to pay over to any organization making such payments any amounts the Trustees have determined to be warranted in order to satisfy the intent of this Plan's coordination of benefits provisions, and the amount so paid will be deemed to be benefits paid under this Plan, and to the extent of such payments, the Trustees shall be fully discharged from liability under this Plan.

C.O.B. WITH MEDICARE

Medicare's C.O.B. provisions will apply to Covered Persons who are entitled to Medicare.

If you or your Dependents who are covered under this Plan are also covered under Medicare and the sum of the benefits payable under this Plan together with the benefits payable under Medicare exceeds the Covered Persons' Allowable Expenses during the Calendar Year (or portion of the Calendar Year where applicable), then the benefits otherwise payable under this Plan with respect to the Covered Person will be reduced so that the benefits payable under Medicare and this Plan will not exceed his or her Allowable Expenses for the Calendar Year.

C.O.B. WITH MEDICARE FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

For Employees Continuing to Work After Age 65

If you continue to work for a Contributing Employer after you reach age 65 and become eligible for Medicare, you are entitled to the same benefits as Employees under age 65 as long as you meet the continuing eligibility rules. The Plan will pay its benefits for you before Medicare pays.

For Spouses Age 65 or Older

If your Spouse is age 65 or older and eligible for Medicare while you are still working and eligible for active employee benefits (regardless of your age), the Plan will pay its benefits for your Spouse before Medicare pays. If your Spouse is covered under another group plan as an employee, that other plan is primary, this Plan is secondary, and Medicare pays next.

Choosing Medicare as Sole Coverage

You (and/or your Spouse) can decline coverage under the Plan when you become eligible for Medicare. If you do, Medicare will be your only health care coverage. If you and/or your Spouse prefer Medicare as your health care coverage when you reach age 65, contact the Fund Office. Unless you make such a choice, the Plan will continue to pay primary for you (and your Spouse) as long as you stay eligible, unless the Plan is legally permitted to pay on a secondary basis.

End Stage Renal Disease

If you or a Dependent are an End Stage Renal Disease beneficiary under Medicare, for a period of up to 30 months, as determined by Medicare, the Plan will pay its benefits for that person before Medicare pays unless the Plan is legally permitted to pay on a secondary basis.

In All Other Cases

The Plan will pay secondary to Medicare when it is allowed to do so by law.

C.O.B. WITH MEDICARE FOR RETIREES AND THEIR DEPENDENTS

- If you, the Retiree, are under age 65 and become eligible for Medicare due to a disability that occurs after you take retirement, the Plan will coordinate benefits with Medicare on your claims, with Medicare as primary.

- If an under age 65 Dependent of yours is or becomes eligible for Medicare due to a disability which occurred before or after your retirement, the Plan will coordinate benefits with Medicare on the Dependent's claims, with Medicare as primary.

- When you or a Dependent become eligible for Medicare due to becoming age 65, Plan coverage will terminate for you or the Dependent, as applicable.

ENROLLMENT IN MEDICARE

Any Covered Person who is eligible to participate in Medicare is responsible for enrolling in Medicare. At present, there is no cost for Part A, which provides hospital benefits. Part B covers such items as Doctors' and nurses' services. Part D covers prescription drugs. There is a monthly charge for Parts B and D.

Any person who wants information about Medicare enrollment should contact his or her local Social Security Administration office before he or she reaches age 65, if possible.

For Employees, there are time limits for enrolling in Medicare Parts B and D and certain penalties apply for late enrollment. This may also apply to your Spouse. You should check with the Social Security Administration about these rules.

Retirees should refer to the important information in the *When You Are Age 65* section.

FUND RIGHT OF SUBROGATION (REIMBURSEMENT)

If you or your Dependent is injured in an accident for which someone else may be liable, that person, his or her insurance carrier or your own insurance carrier may be responsible for paying your or your Dependent's medical expenses.

"Subrogation" means the right of the Plan to be substituted in place of any Covered Person with respect to that Covered Person's lawful claim, demand or right of action against a third party who may have caused the Covered Person's injury or illness that resulted in a payment of benefits by the Plan.

If you submit a claim on behalf of yourself, your Dependent, or on behalf of your minor Dependent for benefits for which someone else may be legally responsible, you will be asked to sign a subrogation and reimbursement agreement as required by the Plan before any payments will be made on the claim.

If the Plan pays benefits on a claim and you recover any amount in connection with the accident or injury from any party or parties (including your own automobile insurance carrier), whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified, the Plan will be reimbursed from the first dollar received, the full amount of the benefits it paid on your or your Dependent's behalf. You or your Dependent will be required to pay your own legal fees and costs and to hire only attorneys who agree to waive the common fund doctrine and to remit the gross rather than the net proceeds from litigation. The Plan will pay no legal costs or fees without receiving a recovery and then only within the terms of this provision. In the

event that an attorney is hired by you, your Dependent or on behalf of a minor Dependent and the Plan is not given notice and an opportunity to pursue its own subrogation recovery, the Plan will not be required to hire or pay any amounts to such attorney. If the attorney, representing you or your Dependent nevertheless wishes to proceed, and creates a common fund in which subrogation is specifically paid, the Plan may agree to pay an amount not to exceed one-third of the amount of the benefits paid by the Plan plus pro rata costs. If less than the full amount paid by the Plan is received from any third party, you must pay the Plan the amount received less its share of attorney's fees and costs, not to exceed an amount equal to one-third of the amount of the benefits paid by the Plan plus pro rata costs. The Plan will have a reimbursement right to any amount received by you, your Dependent and representatives (including an attorney) that is due to the Plan under the subrogation and reimbursement agreement, and any such amount will be deemed to be held in trust by you or by them for the benefit of the Plan until paid to the Plan.

When you choose not to pursue the liability of a third party, the Plan may litigate, compromise, or settle any of your claims against a third party, or otherwise responsible party or parties, to the extent of the benefits paid by the Plan. The Plan will be entitled to institute a legal action or claim against the responsible party or parties, against any uninsured or underinsured insurance coverage, or against any other first-party or third party contract or claim in the name of the Plan, the Trustees, or the Covered Person in order that the Plan may recover all amounts advanced on behalf of the Covered Person. The Plans' expenses, costs and incurred attorneys' fees will also be paid out of any recovery or settlement.

You must take all necessary action and cooperate fully with the Plan in the recovery of the full amount of benefits paid by the Plan and in the Plan's exercise of its rights of reimbursement and subrogation. You must provide the Plan with any and all relevant information and records it requests that relate to the accident or to any claims arising out of the accident, including notifying the Plan or its attorneys of the status of any claim or legal action asserted against any party or insurance carrier and of your receipt of any recovery. You must not do anything to impair or prejudice the Plan's rights in this matter, including releasing or discharging any claim or responsible party, effect any settlement, dismiss any legal action against any source who may be responsible for paying damages or providing compensation, without first notifying the Plan's attorney and tendering to the Plan's attorney the full amount of reimbursement due the Plan.

If you refuse to cooperate with the Plan regarding its subrogation or reimbursement rights in this matter, the Plan, if the Trustees in their sole discretion determine it to be in the Plan's best interest, the Trustees have the right to recover the full amount of all benefits paid by methods which include, but are not necessarily limited to, offsetting such amounts against your future benefit payments under the Plan and those of your Dependents, as applicable.

Once your claim or lawsuit against a third party or parties arising out of this accident has been settled or judgment reached, claims arising out of the accident will not be payable.

The Trustees will pay your or your Dependent benefits if, in its sole discretion, it determines that you or your Dependent cannot recover from a liable third party.

PAYMENT OF BENEFITS

Benefits are payable individually for you and each of your Dependents up to, but not to exceed, the maximum benefits shown in the Schedules of Benefits according to the following rules.

1. Benefits are payable when the required forms and bills have been submitted within the applicable time limits. Any obligation to pay benefits for any loss that is based on incurred charges is expressly conditioned on those charges being considered Covered Expenses under the Plan.

2. All benefit payments (except Loss of Life Benefits) will be made to you (even if the claim is for one of your Dependents) except when benefits are assigned or except as follows:

   a. The Plan's share of a Covered Person's Covered Medical Expenses incurred for both PPO and non-PPO Hospital care and for covered Hospice care will be paid directly to the Hospital or Hospice. You are responsible for paying any amounts not paid by the Plan.

   b. If a Child is covered under the Plan under the terms of a Qualified Medical Child Support Order, benefits will be paid to the Child or his or her custodial parent, or to a medical provider under a valid assignment of benefits.

3. If the Plan determines that a Covered Person to whom benefits would otherwise be paid is incompetent and not capable of handling his or her business affairs and no guardian has been appointed, the Plan may pay benefits (other than Loss of Life Benefits) to the individual who, in the opinion of the Trustees, has assumed the care and principal support of the Covered Person. If the person dies before all amounts that are due have been paid, the Plan may make payment to the Covered Person's estate, to his or her surviving Spouse, child, or children or to any individual whom the Trustees determine is entitled to the benefits.

4. Any payments that are made by the Plan in accordance with these provisions will fully discharge the liability of the Plan to the extent of the payments.

5. The above rules do not apply to prescription drug benefits; benefits are payable by the Plan directly to the pharmacy benefit manager after applicable copayments are made by the Covered Person.

DISCOUNTS, SETTLEMENTS AND REBATES

The Plan may from time to time enter into agreements with medical providers, dental, vision and prescription drug providers to receive discounts on services or supplies rendered by such providers. No claimant or other persons will have any interest in, nor are they entitled to participate in, such discounts. All copay percentages and deductibles will be based on billed, not discounted, amounts.

Release of Information

If you file a claim for benefits and do not provide the Fund Office with any required authorizations for release of necessary information relating to the claim, the Trustees have the right not to pay the claim.

EXAMINATIONS

If the Trustees request a medical examination by a Doctor of their choosing, of a Covered Person for whom benefits are being claimed, or if they request a release giving them the right to examine Hospital or medical records relating to a claim, no benefits under the Plan will be payable until such examination has been completed or a release has been provided, as applicable. In the event the Trustees request an autopsy in order to determine whether a benefit is payable under the Plan, no benefits under the Plan will be payable until the autopsy has been completed.

TRUSTEE AUTHORITY AND INTERPRETATION

The Board of Trustees has the authority and expressly reserves the right, at any time and from time to time in its sole and unrestricted discretion, to interpret the Trust Agreement, the SPD, and procedures of

the Fund. The Trustees' interpretation is binding on all Covered Persons, Eligible Employees, Eligible Retirees, Dependents and Beneficiaries, and all other individuals unless the Trustees' interpretation is found by a court of competent jurisdiction to be arbitrary and capricious. All questions or controversies of any type arising in any manner or between any persons in connection with the Plan or its operation, whether regarding a claim for benefits, interpretation of the Plan language or its rules and regulations adopted by the Trustees, or regarding any writing, decision, instrument or account in connection with the operation of the Plan or otherwise, will be submitted to the Trustees or their delegates for decision. Benefits under the Plan will be paid only when the Board of Trustees, or persons delegated by them to make such decisions, decides, in their sole and unrestricted discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan. If a claim for benefits has been denied, no lawsuit or other action against the Fund or its Trustees may be filed until the matter has been submitted for review under the ERISA-mandated review procedure explained in the *Claim and Appeal Procedures* section. The decision on review will be binding on all persons dealing with the Plan or claiming any benefits under the Plan, except to the extent that such decision is determined to be arbitrary or capricious by a court of competent jurisdiction.

The Board of Trustees, at any time and from time to time in its sole and unrestricted discretion, has the authority to increase, decrease, or change benefits, eligibility rules, or other provisions of the Plan of Benefits. All benefits of the Plan are conditional and subject to the Trustees' authority under the Trust Agreement to change them.

The Trustees or, where the Trustee responsibility has been delegated to others, such other persons shall, subject to the requirements of applicable law, be the sole judges of the standard of proof required for any matter herein and the application and interpretation of the Plan, and decisions of the Trustees or their delegates will be final, conclusive, and binding.

The right to change or eliminate any and all aspects of benefits provided for Retirees is a right specifically reserved to the Trustees, since coverage for Retirees is neither an "accrued benefit" nor a vested benefit and the coverage is subsidized. If the Trustees determine that the amount of the subsidy by the Fund reaches a level that accounts for too large a part of Plan costs, or determine that other economic conditions warrant such action, the Trustees may reduce such coverage, initiate or increase Self-payments for the coverage, or completely terminate such coverage, at any time and from time to time and at their sole and unrestricted discretion.

CIRCUMSTANCES THAT MAY RESULT IN CLAIM DENIALS OR LOSS OF BENEFITS

The Trustees or their designated representatives are authorized to deny payment of a claim; and the reasons for denial may include one or more of the following:

1. The person on whose behalf the claim was filed was not eligible for benefits on the date the expenses were incurred.

2. The claim was not filed within the Plan time limits.

3. The expenses that were denied were or are not considered Covered Expenses under the Plan or the expenses for which the claim was filed were not actually incurred.

4. The claim was for Mental Health or Chemical Dependency inpatient treatment, but the services were not precertified as Medically Necessary by the Mental Health and Chemical Dependency Review Manager.

5. The Covered Person for whom the claim was filed had already received the maximum benefit allowed for that type of expense during a stated period of time, for instance a Calendar Year maximum benefit, a lifetime maximum benefit, an allowed number of days, etc.

6. Another plan was primarily responsible for paying benefits for the expenses.

7. No payment was made, or payment was limited, because a deductible had not been satisfied and some or all of the expenses were applied against the deductible.

8. A third party was responsible for the injury or sickness for which a claim was filed, and you or the Covered Person on whose behalf the claim was filed did not submit the required subrogation documents that would permit the Plan to pay the claim and recover payment from the third party or his insurance company.

9. The Plan of Benefits was terminated.

The above is not an all-inclusive listing of the circumstances that may result in denial or loss of benefits. It is only representative of the types of circumstances, in addition to failure to meet the eligibility requirements, that might cause denial of a claim for benefits.

HIPAA CERTIFICATES OF COVERAGE

When you or a Dependent are no longer eligible for Plan benefits, you have a right to request a certificate of coverage from the Fund Office. This certificate provides evidence of your prior health care coverage under the Plan. You may need to furnish this certificate if you become eligible under another group health plan that excludes coverage for pre-existing conditions. You may also need this certificate in order to buy an individual insurance policy that has a pre-existing condition exclusion or limitation. You also have the right to request one for any other reason. Just call or write the Fund Office to request a certificate. You may request a certificate any time within 24 months of when you were last covered under the Plan.

If your coverage terminates due to termination of employment or reduction in hours, the Fund Office will automatically send a certificate of coverage to you at your last known address. If the Fund Office is notified in writing that a Dependent's coverage has terminated, the Fund Office will also send one to your Dependent's last known address. In addition, a certificate of coverage will be provided to you and/or your Dependents upon the termination of COBRA Continuation Coverage or USERRA continuation coverage.

MISREPRESENTATION OR FALSIFICATION OF A CLAIM

If you (as the claimant) furnish false information on any material subject to the Plan, or to any of its agents or employees, the Trustees may deny all or part of your claim and may charge you for any expenses incurred related to the false information. If benefits have already been paid, based on the false information on a material subject, the Trustees may recover the benefits from you, plus expenses incurred in such recovery, including attorney's fees, costs and any and all other expenses, and/or may reduce future benefits for your claims until the Plan has recovered the benefits paid and expenses incurred.

GOVERNING LAW

This Plan was created and accepted in the State of Illinois. All questions about the validity or interpretation of the Trust Agreement or the SPD or any questions concerning the acts and transactions of the Trustees or any other matter that affects the Fund will be determined under federal law, where

applicable federal law exists. If there is no applicable federal law, the laws of the State of Illinois will apply in all matters.

SEVERABILITY CLAUSE

If any provision of the Trust Agreement or the SPD or any amendment made to the Trust Agreement or the Plan is determined or judged to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions of the Trust Agreement or Plan. To the extent permitted by law, the Trustees will not be held liable for any act done or performed in pursuance of any provisions hereof prior to the time that such act or provision will be held unlawful by a court of competent jurisdiction.

WORKERS' COMPENSATION

The Plan is not in lieu of and does not affect any requirement for coverage under any workers' compensation law or occupational disease law. Benefits which would otherwise be payable under the provisions of such laws will not be paid by the Plan merely because the Covered Person fails or neglects to file a claim for benefits under the provisions of such laws.

RIGHT OF RECOVERY

Whenever payments have been made by the Trustees with respect to Covered Expenses in a total amount at any time in excess of the maximum amount of payment necessary at that time to satisfy the intent of the provision, the Trustees shall have the right to recover such payments on behalf of a Covered Person (including the right to withhold future benefits), to the extent of such excess, from among one or more of the following, as the Trustees shall determine:

1. any Covered Persons to whom or for whom such payments were made;

2. any insurance companies; and

3. any other organizations.

RELEASE OF INFORMATION

An Eligible Employee, Eligible Retiree, Dependent, or Beneficiary making application for benefits shall be required by the Trustees to authorize any Doctor, Hospital, Employer, government agency, or any other person, corporation, or organization having information that may be required for a proper determination of the claim by the Trustees to release such information to the Trustees. Such Eligible Employee, Eligible Retiree, Dependent, or Beneficiary shall, at the request of the Trustees, execute written authorizations necessary to accomplish this purpose.

IMPORTANT INFORMATION ABOUT YOUR RIGHTS

TO PRIVACY & SECURITY

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality and security of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment and is available from the Fund Office.

The Fund will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Fund has required all of its business associates to also observe HIPAA's privacy and security rules.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and request to amend the information. You also have the right to file a complaint with the Fund or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

The Fund maintains a Notice of Privacy Practices, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the Notice, or if you have questions about the privacy and security of your protected health information, please contact the Fund's Privacy Officer.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Notwithstanding any other provision of the Plan to the contrary, the Plan will provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO) as defined in ERISA Section 609(a).

Any payment for benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient's custodial parent or legal guardian will be made to the alternate recipient or the alternate recipient's parent or legal custodian.

Upon receipt of a QMCSO, the Fund Office will promptly notify the Eligible Employee (or Eligible Retiree) and each alternate recipient, as that term is defined in ERISA Section 609 (a), of the receipt of such order and the Plan's procedures for determining whether the order is a QMCSO. The Fund Office will then determine whether the order is a QMCSO pursuant to the Plan's procedures and notify the Eligible Employee (or Eligible Retiree) and each alternate recipient of the determination.

TERMINATION OF PLAN

The Trustees reserve the right to modify and terminate the Plan at any time, and from time to time, without cause. If the Plan is terminated, benefits for Covered Expenses incurred before the termination date will be paid to eligible individuals as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets. If there are any excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Trustees in accordance with the provisions of the Trust Agreement.

ERISA Rights

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 as amended (ERISA). ERISA provides that all Plan Participants are entitled to certain rights, as described in this section.

RECEIVE INFORMATION ABOUT THE PLAN AND YOUR BENEFITS

You have the right to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These include insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

- Obtain, upon written request to the Fund Office, copies of documents governing the Plan's operation. These include insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Fund Office may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan is required by law to furnish each Participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You also have the right to:

- Continue health care coverage for yourself, Spouse, or Children if there is a loss of coverage under the Plan because of a qualifying event. You or your Dependents must payfor such coverage. Review this SPD and other documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when:

  - You lose coverage under the Plan;

  - You become entitled to elect COBRA Continuation Coverage; or

  - Your COBRA Continuation Coverage ends.

You must request the Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage under a new plan.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate ther Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, the Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. For instance, if you request a copy of the SPD or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries misuse the Plan's money, or if you believe you were discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about the Plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Manager, you should contact the Employee Benefits Security Administration (EBSA), U.S. Department of Labor at:

Nearest Regional Offices:
Illinois (northern):
Chicago Regional Office
230 South Dearborn Street, Suite 774
Chicago, Illinois 60604
312-596-7160

Illinois (southern):
St. Louis District Office
1222 Spruce Street
Room 9, 109E
St. Louis, MO 63103
314-539-2667

National Office:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210
866-444-3272

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact EBSA by visiting their web site at www.dol.gov/ebsa.

INFORMATION ABOUT THE PLAN OF BENEFITS

NAME OF PLAN

The name of the Plan is the Roofers' Unions Welfare Trust Fund.

PLAN SPONSORSHIP AND ADMINISTRATION

The Plan is sponsored and administered by a joint labor-management Board of Trustees. The address of the Board of Trustees and the names and addresses of the individual Trustees are shown on the last page of the SPD. The Board of Trustees is the "named fiduciary" of the Plan. The Board of Trustees may adopt rules they consider necessary to aid them in administering the Plan. The Board of Trustees is assisted in its administration of the Fund by a Fund Manager who maintains all Fund records and is responsible for processing benefit payments.

SERVICE OF LEGAL PROCESS

The agent for service of legal process is the Fund Manager. Service of legal process may also be made on any Trustee at the Fund Office.

SOURCE OF FINANCING; PLAN PARTICIPATION

The Fund receives Contributions from Employers under the terms of Collective Bargaining Agreements with the Union. Contributions are also received from Employees, Retirees, and Dependents in accordance with the COBRA rules and self-payment rules. You are entitled to participate in the Plan if you work under one of the Collective Bargaining Agreements and if your Employer is obligated to make Contributions to the Fund for you and you meet the eligibility requirements.

ACCUMULATION OF ASSETS; PAYMENT OF BENEFITS

Employer Contributions as well as Employee, Retiree, and Dependent Self-Payments and COBRA payments are received and held in trust by the Trustees pending payment of benefits and administrative expenses. The Fund provides loss of life, accidental death and dismemberment, weekly disability, comprehensive medical expense, dental (including orthodontia and periodontal), vision, and prescription drug benefits on a self-funded basis, although all Covered Persons may not be entitled to all such benefits. When benefits are self-funded, the benefits are paid directly from the Fund to Covered Persons or to providers if benefits have been assigned by the Covered Person. The Plan is not insurance nor is the Plan of Benefits an insurance policy and no benefits are provided by an insurance company.

PLAN YEAR

The Fund's financial records are maintained on a 12-month Calendar Year basis, beginning January 1 and ending December 31 of each year.

FUND/PLAN IDENTIFICATION NUMBERS

The Fund's Employer Identification Number (EIN) is 36-2226396. The Plan Numbers are: Plan II and II-PA-PN 502; Plan III -PN 503.

COLLECTIVE BARGAINING AGREEMENT

The relevant provisions in the Collective Bargaining Agreement determine the hourly rate at which Employers contribute to the Plan and the Employees on whose behalf contributions are made. Upon written request, you and/or your Dependents may obtain:

- information about whether an employer is required to pay contributions to the Plan;
- the address of a Contributing Employer; and
- copies of the Collective Bargaining Agreement.

You or your Dependents may also examine these documents and information at your local Union office.

This SPD is meant to be an easy-to-understand description of the plans of benefits. This SPD also serves as the Plan Document, which is the Plan's official rules and regulations. The Plan is governed by this document and by the Trust Agreement establishing the Plan, including any amendments and attachments.

FUND PROFESSIONALS	
FUND MANAGER Ms. Julie A. Rachal Roofers' Unions Welfare Trust Fund Suite 305 2340 S. River Road Des Plaines, IL 60018-3251	**FUND CONSULTANT** The Segal Company Suite 500 101 N. Wacker Drive Chicago, IL 60606
FUND ATTORNEYS Ogletree, Deakins, Nash, Smoak & Stewart, P.C. Suite 4300 155 North Wacker Drive Chicago, IL 60606 Johnson & Krol, L.L.C. Suite 1313 300 South Wacker Drive Chicago, IL 60606	**AGENT FOR SERVICE OR LEGAL PROCESS** Ms. Julie A. Rachal Fund Manager Roofers' Unions Welfare Trust Fund Suite 305 2340 S. River Road Des Plaines, IL 60018-3251
FUND AUDITOR Bansley & Kiener, L.L.P Suite 200 8745 W. Higgins Road Chicago, IL 60631	

BOARD OF TRUSTEES	
Roofers' Unions Welfare Trust Fund Suite 305 2340 S. River Road Des Plaines, IL 60018-3251	
UNION TRUSTEES	**EMPLOYER TRUSTEES**
Mr. Gary Menzel President and Business Manager United Union of Roofers, Waterproofers and Allied Workers, Local No. 11 9838 West Roosevelt Road Westchester, IL 60154-2782	Mr. William C. Lynch President Olsson Roofing Company, Inc. 740 South Lake Street Aurora, IL 60507-1450
Mr. Lawrence G. Gnat Business Agent United Union of Roofers, Waterproofers and Allied Workers, Local No. 11 9838 West Roosevelt Road Westchester, IL 60154-2782	Mr. William E. O'Brien Executive Vice President Combined Roofing, Inc. 621 West Washington Street West Chicago, IL 60185-2701
Mr. Martin Headtke Apprenticeship Coordinator Chicagoland Roofers' Apprenticeship and Training Fund 7045 Joliet Road Indian Head Park, IL 60525	Mr. Christopher M. Cronin President Knickerbocker Roofing & Paving Company, Inc. 16851 South Lathrop Avenue Harvey, IL 60426